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ABSTRACT

The manual delineates the roles of the mental health professional in identification, treatment, and prevention of child maltreatment. Chapters cover the following topics (sample subtopics in parentheses): nature of child abuse and neglect (definitions, extent, and causes); reasons for involvement by mental health professionals (mental health and community, legal, and ethical issues); reporting child abuse and neglect (state laws and difficulties encountered); assessment and treatment planning (assessment of parents, assessment of children, and the evaluation report); treatment (treatment goals, treatment alternatives, and treatment for parents); the mental health professional's involvement with the courts (the role of the courts and testimony); support of the child protection system (development of agency capabilities, development of an interagency network, and community coordination); and prevention (mental health based programs, mental health-community programs, and public awareness programs). Appended are federal standards applicable to the role of the mental health professional and a sample qualified service organization agreement. (DB)

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THE ROLE OF THE MENTAL HEALTH PROFESSIONAL IN THE PREVENTION AND TREATMENT OF CHILD ABUSE AND NEGLECT

EC 140372



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THE ROLE OF THE MENTAL HEALTH PROFESSIONAL

IN THE PREVENTION AND TREATMENT OF CHILD ABUSE AND NEGLECT

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with
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PREFACE

Traditionally, the public and private mental health systems have not been involved in the problems arising from child maltreatment. Some mental health professionals have considered the problem of child abuse and neglect to be identical to other social problems and have failed to provide specialized services. On the other hand, other mental health practitioners have made significant contributions to the identification, treatment and prevention of child maltreatment.

This manual delineates the many roles of the mental health professional in child abuse and neglect identification, treatment and prevention. It is designed for use by a wide range of both public and private mental health facilities and individual practitioners.

This manual may also be used by other professionals dealing with child maltreatment and by concerned citizens wanting to better understand the mental health professional's role in the child protection system.

The Role of the Mental Health Professional in the Prevention and Treatment of Child Abuse and Neglect is one in a series of manuals based on the Draft Federal Standards for Child Abuse and Neglect Prevention and Treatment Programs and Projects.* (A list of the Standards related to the mental health system will be found in Appendix A.) This manual focuses on the following:

- Why mental health professionals should be involved in the child protection system
- How to recognize child abuse and neglect
- Steps to take when reporting suspected child abuse and neglect
- Mental health professionals' involvement in the diagnostic and treatment planning process

*Other manuals in this series address related topics such as the role of other professionals in dealing with child abuse and neglect; community planning; self-help; and the role of the courts. Readers are encouraged to consult other manuals for additional information on how child abuse and neglect can be most effectively addressed by the community. Information about the other manuals in the series may be obtained from the National Center on Child Abuse and Neglect.

- Mental health practitioners' role in the treatment of child abuse and neglect
- Mental health practitioners' involvement in the court process
- Mental health professionals' participation in community coordination
- Prevention of child abuse and neglect as a function of both the mental health facility and the individual practitioner.

I

OVERVIEW OF CHILD ABUSE AND NEGLECT

DEFINITIONS OF CHILD ABUSE AND NEGLECT

The words "child abuse" and "child neglect" mean different things to different people. It is important to have a widely accepted definition of these terms because they describe the situations in which society should and must intervene, possibly against parental wishes, to protect a child's health or welfare. But defining these terms raises the most controversial issues in child abuse and neglect work because they determine the conditions which constitute reportable circumstances and they establish when society, child protective services, law enforcement, and possibly the courts, can intervene in family life.

Many people believe that definitions of child abuse and neglect are either too broad or too narrow. It is difficult to draft legislation which is specific enough to prevent improper application and yet broad enough to cover situations of harm to a child necessitating societal intervention.

As a result, there are many different approaches to defining "child abuse" and "child neglect." One approach is found in the Model Child Protective Services Act:

- (a) "Child" means a person under the age of 18.
- (b) An "abused or neglected child" means a child whose physical or mental health or welfare is harmed or threatened with harm by the acts or omissions of his/her parent or other person responsible for his/her welfare.
- (c) "Harm" to a child's health or welfare can occur when the parent or other person responsible for his/her welfare:
 - (i) Inflicts, or allows to be inflicted, upon the child, physical or mental injury, including injuries sustained as a result of excessive corporal punishment; or
 - (ii) Commits, or allows to be committed, against the child, a sexual offense, as defined by state law; or

- (iii) Fails to supply the child with adequate food, clothing, shelter, education (as defined by state law), or health care, though financially able to do so or offered financial or other reasonable means to do so; for the purposes of this Act, "adequate health care" includes any medical or non-medical health care permitted or authorized under state law; or
- (iv) Abandons the child, as defined by state law; or
- (v) Fails to provide the child with adequate care, supervision, or guardianship by specific acts or omissions of a similarly serious nature requiring the intervention of the child protective service or a court.
- (d) "Threatened harm" means a substantial risk of harm.
- (e) "A person responsible for a child's welfare" includes the child's parent; guardian; foster parent; an employee of a public or private residential home, institution or agency; or other person responsible for the child's welfare.
- (f) "Physical injury" means death, disfigurement, or the impairment of any bodily organ.
- (g) "Mental injury" means an injury to the intellectual or psychological capacity of a child as evidenced by an observable and substantial impairment in his ability to function within a normal range of performance and behavior, with due regard to his culture.

Variations in Definitions of Child Abuse and Neglect

States and communities have a variety of definitions of child abuse and neglect; some are found in laws, some are found in procedures, and some are found in the informal practices of those agencies assigned to implement laws concerning child abuse and neglect.

It is important that mental health professionals be aware of the various formal definitions in their community; these can be found in

1. Criminal Law Definition - those forms of child abuse and neglect which are criminally punishable.
2. Juvenile Court Act - those forms of child abuse and neglect which authorize the court to provide protective services and, when necessary, remove children from their parents.
3. Reporting Law Definition - those forms of known or suspected child abuse and neglect which require reporting by some persons and permit reporting by others. These reports activate the child protective process which can result in either juvenile court or criminal court action.

Each of these definitions has been developed to meet the specific purposes of each function. Although there is a growing convergence of these definitions, they often differ. Most likely the criminal law will focus on specific acts of the parents in such a way as to isolate criminal intent as a reason for prosecution. Most likely, the juvenile court definition will focus on harm to the child as a justification for taking protective steps in relation to the child. And finally, the reporting act will probably describe apparent situations which give rise to sufficient cause for concern ("reasonable cause to believe") to require the investigation of the home situation and the danger to the child by some appropriate investigative agency.

EXTENT OF CHILD ABUSE AND NEGLECT

Because child abuse and neglect usually occur in the privacy of the home, no one knows exactly how many children are affected. Child abuse and neglect must be discovered and reported before the child can be protected, and there is general agreement that this never happens in a majority of abuse and neglect incidents.

There have been a number of estimates made of the incidence of child maltreatment, ranging from 500,000 to 4.5 million, but they are unproven. The National Center on Child Abuse and Neglect estimates that approximately one million children are maltreated by their parents each year. Of these children, as many as 100,000 to 200,000 are physically abused, 60,000 to 100,000 are sexually abused, and the remainder are neglected. And each year, more than 2,000 children die in circumstances suggestive of abuse or neglect.

CAUSES OF CHILD ABUSE AND NEGLECT

No one factor accounts for child abuse and neglect. There are a variety of manifestations and causes. Some generally accepted causes of the abuse and neglect of children include severe emotional pressures or psychopathologies, a family heritage of violence, and the burdens resulting from poverty. Instead of one factor which leads to abuse or neglect, there are multiple forces on the family which reinforce each other and which cause abuse and neglect. It is possible to divide these forces into four categories: individual capacities, attitudes and values, specific life situations, and general community welfare.

Individual Capacities

Individual capacities include such factors as physical health, mental health, intelligence, personality and previous life experiences, such as past maltreatment. All of these personal characteristics operate in parents and children, and they reflect both innate and experiential influences. These are probably the most constant influences on behavior.

Attitudes and Values

There are a variety of cultural forces which are incorporated as attitudes and values by individuals and which influence families and their relationships. These forces always exist, but they change less frequently than the other forces impacting on families.

These forces include attitudes toward: children, changing family roles, violence, corporal punishment, economic and social competition and religion among others.

Specific Life Situations

Situational forces, either chronic or acute, may affect parents' relationships with their children. There forces can include marital relationships, employment situations, presence of extended family members, housing conditions, financial security and amount of social contact. If these forces have a positive effect, they can strengthen family ties, whereas if they are negative they reinforce any other problems which the family is experiencing.

General Community Welfare

The general community welfare is largely defined by social institutions which affect families on various levels, depending on the purpose of the institution. For example, some institutions, including businesses, churches, schools, police, fire departments, radio, television and newspapers, affect everyone. Some institutions, which are more problem-oriented, affect only specific groups. These include such institutions as mental health departments, child welfare institutions, drug and alcohol abuse clinics, poverty or social welfare institutions. On a third level are those institutions that deal directly with problems of child abuse and neglect, such as child protective services and juvenile courts.

Forces in Combination

Any of these forces can have either a positive or negative affect on the occurrence of child abuse and neglect. They may either contribute to the well-being of the family and thus help to prevent child abuse and neglect; or they may exacerbate the problems of family members and generate new crises which could cause child abuse and neglect.

Child abuse and neglect are most likely to occur when there is a combination of negative forces affecting the family. These forces work together and reinforce each other. Such a combination can be quite devastating, especially for a family which is not as well equipped to cope with problems as most other families.

EFFECTS OF CHILD ABUSE AND NEGLECT

Child abuse and neglect can result in permanent and serious damage to the physical, emotional, and mental development of the child. The physical effects of child abuse and neglect may include damage to the brain, vital organs, eyes, ears, arms or legs. These injuries may, in turn, result in mental retardation, blindness, deafness or loss of a limb. Abuse or neglect may cause arrested development. At its most serious, of course, abuse or neglect may result in the death of a child.

Child abuse and neglect are often as damaging emotionally as they are physically. Abused and neglected children may be impaired in self concept, ego competency, reality testing, defensive functioning and overall thought processes. They also often have a higher level of aggression, anxiety, low impulse control, and self-destructiveness. These characteristics can cause abused or neglected children to display high levels of antisocial behavior as they get older.

Abuse and neglect may also result in restricted cognitive development. Language, perceptual, and motor skills are often underdeveloped, further hindering the child's chances to succeed.

II

WHY MENTAL HEALTH PROFESSIONALS SHOULD BE INVOLVED

There are numerous reasons why mental health professionals should be involved in the child protection system. Among them are that practitioners work with and for children, parents and families; that the law mandates their involvement and professional responsibility dictates it; and that mental health professionals have a personal commitment to the health and emotional well-being of people.

MENTAL HEALTH AND COMMUNITY ISSUES

Because mental health professionals are the primary resource for individuals experiencing emotional difficulties, they inevitably become involved in the identification, treatment and prevention of child abuse and neglect. They are likely to come in contact with children who display physical and behavioral manifestations of child maltreatment. Likewise, practitioners frequently treat parents whose attitudes and behavior indicate either the existence of or potential for child abuse and neglect problems. For these reasons, mental health professionals are in a unique position to help these children, their families, child protective services (CPS) and the community in alleviating the causes and effects of child maltreatment.

LEGAL ISSUES

State laws support the involvement of mental health professionals in the detection of child abuse and neglect. Most state statutes require practitioners to report suspected cases of child maltreatment. In fact, many provide penalties for mental health practitioners who do not report. The range of mental health professionals required to report is broad. It includes psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, counselors, and paraprofessionals. These mental health professionals may practice independently, within mental health facilities or agencies, or within physical health, social welfare and judicial systems.

PREVENTION AND TREATMENT ISSUES

Of all the professionals in the community, mental health practitioners have the expertise to provide assistance to CPS or the judicial system in assessing and planning treatment for families experiencing child abuse

and neglect problems. They have knowledge which is invaluable to the child protection system, including an understanding of human behavior and the skills to diagnose emotional problems.

In addition, because of their knowledge, training, and skills, mental health professionals are a vital resource in providing treatment to abused and neglected children and their families. It is essential that practitioners take an active role in this process and that they coordinate their efforts through the agency with the legal mandate to deal with child maltreatment.

Mental health professionals are an effective prevention resource, for many of the same reasons that they are effective treatment providers. They have the opportunity and responsibility to provide services to individuals and families at risk. Likewise, they have the capability to provide a range of services to the general public to improve parenting and interactional skills.

ETHICAL ISSUES

Mental health practitioners have a strong professional and personal commitment to the emotional well-being of people. Because of their choice of occupation, they are morally obligated to provide services to those who are in the greatest need.

Mental health professionals' specialized training and skills enable them to have a positive impact on families experiencing child maltreatment problems. The practitioner's failure to provide services to these individuals denies them access to the most valuable treatment resource in any community.

Many child abuse and neglect prevention and treatment practices appear to be in direct conflict with the separate ethics of mental health treatment; namely, the sanctity of the professional-client relationship. However, child protection does not necessarily come naturally to mental professionals; it is not directly related to treatment skills. The ethics of treatment and those of child protection can be combined if professionals recognize the limitations of their skills and can see the need for child protection beyond the capacity of therapy.

III

RECOGNIZING CHILD ABUSE AND NEGLECT

Mental health professionals are in a unique position to detect child maltreatment, particularly with regard to the behavioral manifestations. Mental health practitioners can often identify child abuse and neglect by recognizing physical and behavioral indicators in the child's appearance or behavior and in parental attitudes and behaviors.

Physical indicators of child abuse and neglect are indicators which are usually readily observable. They may be mild or severe, but they involve the child's physical appearance. Frequently, physical indicators are skin or bone injuries, or evidence of lack of care and attention manifested in conditions such as malnutrition.

Mental health professionals are trained observers of human behavior. They are sensitive to the range of behavior expected of children of a given age group, and they are quick to notice behaviors which fall outside this range. A child's behavior can often be a clue to the presence of child abuse and neglect. Behavioral indicators may exist alone or may accompany physical indicators. They range from subtle clues that something is amiss, to statements by children that they have been physically assaulted or sexually molested.

Mental health professionals are also sensitive to parental statements and behaviors which may indicate inappropriate parenting. These verbalizations or behaviors may be very blatant or they may be subtle clues to underlying problems.

INDICATORS IN THE CHILD

Physical and behavioral indicators are displayed in Exhibit I, following this page. The list is not intended to be exhaustive; many more indicators exist than can be included. In addition, the presence of a single indicator does not necessarily prove that child abuse or neglect is occurring. However, the repeated occurrence of an indicator, the presence of several indicators in combination, or the appearance of serious injury or suspicious death should alert the mental health professional to the possibility of child abuse or neglect.

EXHIBIT I

PHYSICAL AND BEHAVIORAL INDICATORS OF CHILD ABUSE AND NEGLECT

TYPE OF CASE	PHYSICAL INDICATORS	BEHAVIORAL INDICATORS
PHYSICAL ABUSE	Unexplained Bruises and Welts: - on face, lips, mouth - on torso, back, buttocks, thighs - in various stages of healing - clustered, forming regular patterns - reflecting shape of article used to inflict (electric cord, belt buckle) - on several different surface areas - regularly appear after absence, weekend or vacation Unexplained Burns: - cigar, cigarette burns, especially on soles, palms, back or buttocks - immersion burns (sock-like, glove-like, doughnut shaped on buttocks or genitalia) - patterned like electric burner, iron, etc. - rope burns on arms, legs, neck or torso Unexplained Fractures: - to skull, nose, facial structure - in various stages of healing - multiple or spiral fractures Unexplained Lacerations or Abrasions: - to mouth, lips, gums, eyes - to external genitalia	Wary of Adult Contacts Apprehensive When Other Children Cry Behavioral Extremes: - aggressiveness, or - withdrawal Frightened of Parents Afraid to go Home Reports Injury by Parents
PHYSICAL NEGLECT	Consistent Hunger. Poor Hygiene, Inappropriate Dress Consistent Lack of Supervision, Especially in Dangerous Activities or Long Periods Unattended Physical Problems or Medical Needs Abandonment	Begging, Stealing Food Extended Stays at School (early arrival and late departure) Constant Fatigue, Listlessness or Falling Asleep in Class Alcohol or Drug Abuse Delinquency (e.g. thefts) States There Is No Caretaker
SEXUAL ABUSE	Difficulty in Walking or Sitting Torn, Stained or Bloody Underclothing Pain or Itching in Genital Area Bruises or Bleeding in External Genitalia, Vaginal or Anal Areas Veneral Disease, Especially in Pre-teens Pregnancy	Unwilling to Change for Gym or Participate in Physical Education Class Withdrawal, Fantasy or Infantile Behavior Bizarre, Sophisticated, or Unusual Sexual Behavior or Knowledge Poor Peer Relationships Delinquent or Run Away Reports Sexual Assault by Caretaker
EMOTIONAL MALTREATMENT	Speech Disorders Lags in Physical Development Failure-to-thrive	Habit Disorders (sucking, biting, rocking, etc.) Conduct Disorders (antisocial, destructive, etc.) Neurotic Traits (sleep disorders, inhibition of play) Psychoneurotic Reactions (hysteria, obsession, compulsion, phobias, hypochondria) Behavior Extremes: - compliant, passive - aggressive, demanding Overly Adaptive Behavior: - inappropriately adult - inappropriately infant Developmental Lags (mental, emotional) Attempted Suicide

Physical Abuse

Physical abuse of children includes any non-accidental injury caused by the child's caretaker. It may include burning, beating, branding, punching and so on. By definition the injury is not an accident, but neither is it necessarily the intent of the child's caretaker to injure the child. Physical abuse may result from over-discipline or from punishment which is inappropriate to the child's age or condition.

Physical Indicators of Physical Abuse

The following are physical indicators of physical abuse in the child:

- Unexplained bruises and welts

- on the face, lips, or mouth
- in various stages of healing (bruises of different colors, for example, or old and new scars together)
- on large areas of the torso, back, buttocks or thighs
- in clusters, forming regular patterns, or reflective of the article used to inflict them (electrical cord; belt buckle)
- on several different surface areas (indicating the child has been hit from different directions)

- Unexplained burns

- cigar or cigarette burns, especially on the soles of the feet, palms of the hands, back or buttocks
- immersion or "wet" burns, including glove- or sock-like burns and doughnut-shaped burns on the buttocks or genitalia
- patterned or "dry" burns which show a clearly defined mark left by the instrument used to inflict them (e.g. electrical burner; iron)
- rope burns on the arms, legs, neck or torso

- Unexplained fractures
 - to the skull, nose, or facial structure
 - in various stages of healing (indicating they occurred at different times)
 - multiple or spiral fractures
 - swollen or tender limbs
 - any fracture in a child under the age of two
- Unexplained lacerations and abrasions
 - to the mouth, lips, gums or eyes
 - to the external genitalia
 - on the backs of the arms, legs, or torso
- Unexplained abdominal injuries
 - swelling of the abdomen
 - localized tenderness
 - constant vomiting
- Human bite marks, especially when they appear adult size or are recurrent.

Behavioral Indicators of Physical Abuse

Conduct, too, can be a tip-off to the presence of child abuse and neglect. Abused and neglected children may demonstrate certain characteristic behavior or conduct which can be spotted by the mental health professional. For the adolescent particularly, behavior may be the only clue to child abuse and neglect. These behaviors may exist independent of or in conjunction with physical indicators.

The following are some of the behaviors which may be associated with physical abuse. The mental health practitioner should be alert for the child who:

- is wary of physical contact with adults
(The abused child will often avoid it, sometimes even shrinking at the touch or approach of an adult.)

- becomes apprehensive when other children cry
- demonstrates extremes in behavior--extreme aggressiveness or extreme withdrawal, for example--behavior which lies outside the range expected for the child's age group
- seems frightened of the parents
- states he/she is afraid to go home, or cries when it is time to leave
- reports injury by a parent.

Neglect

Neglect involves inattention to the basic needs of a child, such as food, clothing, shelter, medical care, and supervision. While physical abuse tends to be episodic, neglect tends to be chronic. When considering the possibility of neglect, it is important to note the consistency of indicators. Do they occur rarely, or frequently? Are they chronic (there most of the time), periodic (noticeable after weekends or absences), or episodic (seen twice in a time when there was illness in the family)? In a given community or subpopulation, do all the children display these indicators, or only a few? Is this culturally acceptable childrearing, a different lifestyle, or true neglect? Answers to questions like these can be extremely helpful in differentiating between neglect and differing ways of life.

Physical Indicators of Neglect

The following are physical indicators of neglect:

- constant hunger, poor hygiene, or inappropriate clothing
- consistent lack of supervision, especially when engaged in dangerous activities over extended periods of time
- constant fatigue or listlessness
- unattended physical problems or medical needs, such as untreated or infected wounds.

Behavioral Indicators of Neglect

The mental health practitioner should be alert for the child who exhibits the following behaviors:

- begging or stealing food
- constantly falling asleep in class, therapy sessions, activity or play groups
- rare attendance at school
- coming to school or therapy sessions very early and leaving very late
- addiction to alcohol or other drugs
- engaging in delinquent acts such as vandalism or theft
- stating that there is no one to care for or look after him/her.

Sexual Abuse

Sexual abuse includes any contacts or interactions between a child and an adult in which the child is being used for the sexual stimulation of the perpetrator or another person. These acts, when committed by a person under the age of 18 who is either significantly older than the victim or in a position of power or control over another child, may be considered sexual abuse.

Physical Indicators of Sexual Abuse

Sexual abuse is not often identified through physical indicators alone. Frequently a child confides in a trusted counselor or nurse that he or she has been sexually assaulted or molested by a caretaker, and that may be the first sign that sexual abuse is occurring.

There are some physical signs to be alert for, however. These include:

- difficulty in walking or sitting
- torn, stained, or bloody underclothing

- complaints of pain or itching in the genital area
- bruises or bleeding in external genitalia, vaginal or anal area
- venereal disease, particularly in a child under 13
- pregnancy, especially in early adolescence.

Behavioral Indicators of Sexual Abuse

The sexually abused child may:

- appear withdrawn; engage in fantasy or infantile behavior; even appear retarded
- have poor peer relationships
- be unwilling to participate in physical activities
- engage in delinquent acts, or run away
- display bizarre, sophisticated, or unusual sexual knowledge or behavior
- state he/she has been sexually assaulted by a caretaker.

Emotional Maltreatment

Emotional maltreatment includes blaming, belittling or rejecting a child; constantly treating siblings unequally; and deliberate and enforced isolation or continuous withholding of security and affection by the child's caretaker. Emotional maltreatment is rarely manifest in physical signs; speech disorders, lags in physical development, and failure-to-thrive syndrome (which is a progressive wasting away usually associated with lack of mothering) are a few physical indicators of emotional maltreatment. More often it is observed through behavioral indicators, and even these indicators may not be immediately apparent.

There are four criteria implied in the Draft Model Child Protection Act's definition of emotional maltreatment which can help the mental health professional identify possible emotional abuse. The following criteria can help to differentiate emotional maltreatment as a

category of child abuse and neglect from ineffective or even occasionally harmful parental behaviors toward children.

- Emotional maltreatment is a parental (or caretaker) pattern of behavior that has an adverse effect on the child. It causes an emotional or mental injury.
- The effect of emotional maltreatment can be observed in the child's abnormal performance and behavior.
- The effect of emotional maltreatment is long-lasting. The maltreatment brings about an erosion of the child's capacity to think and to feel and is probably a chronic pattern of parental behavior rather than a single or even an occasional lapse on a parent's part.
- The effect of emotional maltreatment constitutes a handicap to the child. It causes substantial impairment of the child's ability to think, to learn, to enter into relationships with others and to find satisfaction in his/her endeavors.

Recognition of emotional maltreatment starts with the effects or symptoms of the effects. For mental health practitioners who do not have the opportunity to observe parent-child interaction over an extended period, the indicators of emotional maltreatment can be observed in the child's behavior. These indicators are almost always more ambiguous than those in cases of physical abuse. The exhibit following this page describes the indicators of emotional maltreatment.

While emotional maltreatment may occur alone, it often accompanies physical abuse and sexual abuse. Emotionally maltreated children are not always physically abused, but physically abused children are almost always emotionally maltreated as well.

The behavior of emotionally maltreated and emotionally disturbed children is similar. However, parental behavior can help to distinguish disturbance from maltreatment. The parents of an emotionally disturbed child generally accept the existence of a problem. They are concerned about the child's welfare and are actively seeking help. The parents of an emotionally maltreated child often blame the child for the problem (or ignore its existence), refuse all offers of help, and are unconcerned about the child's welfare.

EXHIBIT II

INDICATORS OF EMOTIONAL MALTREATMENT*

<u>PARENT BEHAVIOR</u>	<u>CHILD BEHAVIOR</u>	
CONSISTENT/GROSS FAILURE TO PROVIDE:	TOO LITTLE MAY RESULT IN:	TOO MUCH MAY RESULT IN:
Love (empathy) (praise, acceptance, self-worth)	Psycho-social dwarf- ism, poor self- esteem, self-destruc- tive behavior, apathy, depression, withdrawn	Passive, sheltered, naive, "over self- esteem"
Stimulation (emotional/cogni- tive) (talking-feeling-touching)	Academic failure, pseudo-mental retar- dation, developmental delays, withdrawn	Hyperactivity, driven
Individuation	Symbiotic, stranger and separation anxiety	Pseudo-maturity
Stability/permanence/continu- ity of care	Lack of integrative ability, disorgani- zation, lack of trust	Rigid-compulsive
Opportunities and rewards for learning and mastering	Feelings of inade- quacy, passive- dependent, poor self-esteem	Pseudo-maturity, role reversal
Adequate standard of reality	Autistic, delusional, excessive fantasy, primary process, pri- vate (unshared) reality, paranoia	Lack of fantasy, play
Limits, (moral) guidance, consequences for behavior (socialization)	Tantrums, impulsivity, testing behavior, defiance, antisocial behavior, conduct disorder	Fearful, hyperalert, passive, lack of creativity and exploration
Control for/of aggression	Impulsivity, inappro- priate aggressive be- havior, defiance, sadomasochistic behavior	Passive-aggressive, lack of awareness of anger in self/others
Opportunity for extrafamilial experience	Interpersonal diffi- culty (peer/adults), developmental lags, stranger anxiety	Lack of familia attachment, exces- sive peer dependence
Appropriate (behavior) model	Poor peer relations, role diffusion, (deviant behavior, depending on behavior modeled)	Stereotyping, rigidity, lack of creativity
Gender (sexual) identity model	Gender confusion, poor peer relations, poor self-esteem	Rigid, stereotyping
(Sense of) (Provision of) security/safety	Night terrors, anxiety, excessive fears	Oblivious to hazards and risks, naive

*Ira S. Lourie M.D. and Lorraine Stefano. On Defining Emotional Abuse: Results of an NIMH/NCCAN Workshop. *Proceedings of the Second National Conference on Child Abuse and Neglect, 1977, Volume 1.*

EXHIBIT II (Con'd)

INDICATORS OF EMOTIONAL MALTREATMENT*

<u>PARENT BEHAVIOR</u>	<u>CHILD BEHAVIOR</u>	
CONSISTENT/GROSS FAILURE TO PROVIDE:	TOO LITTLE MAY RESULT IN:	TOO MUCH MAY RESULT IN:
Scape-goating, ridicule, denigration		Poor self-esteem, depression
Ambivalence	Rigidity	Lack of purpose, determination, disorganization
Inappropriate expectation for behavior/performance	Poor self-esteem, passivity	Pseudomaturity
Substance abuse	(Depends on behavior while intoxicated)	
Psychosis	(Depends on behavior/type/frequency)	
Threats to safety/health		Night terrors, anxiety, exces- sive fears

*Ira S. Lourie M.D. and Lorraine Stefano. On Defining Emotional Abuse: Results of an NIMH/NCCAN Workshop. *Proceedings of the Second National Conference on Child Abuse and Neglect, 1977, Volume I.*

INDICATORS IN THE PARENT

The behavior and attitudes of the parents, their own life histories, even the condition of their home, can offer valuable clues to the presence of child abuse and neglect. When considering the possibility of child abuse and neglect, the mental health professional should evaluate to what extent the parents seem to be: concerned or unconcerned about the child; looking for solutions or denying the existence of a problem; hostile or cooperative.

The following is a list of characteristics based on a composite of many cases. The list is not exhaustive; many more indicators exist than can be included. Neither does the presence of a single or even several indicators prove that maltreatment exists.

Characteristics of Abusive Parents

Abusive parents:

- seem unconcerned about the child
- see the child as "bad," evil," a "monster" or "witch"
- offer illogical, unconvincing, contradictory explanations or have no explanation of the child's injury
- attempt to conceal the child's injury or to protect the identity of person(s) responsible
- routinely employ harsh, unreasonable discipline which is inappropriate to the child's age, transgressions, and condition
- were often abused as children
- were expected to meet high demands of their parents
- were unable to depend on their parents for love and nurturance
- cannot provide emotionally for themselves as adults
- expect their children to fill their emotional void
- have poor impulse control

- expect rejection
- have low self-esteem
- are emotionally immature
- are isolated, have no support system
- marry a non-emotionally supporting spouse, and the spouse passively supports the abuse.

Characteristics of Neglectful Parents

Neglectful parents:

- may have a chaotic home life
- may live in unsafe conditions (no food; garbage and excrement in living areas; exposed wiring; drugs and poisons kept within the reach of children)
- may abuse drugs or alcohol
- may be mentally retarded, have low I.Q., or have a flat affect
- may be impulsive individuals who seek immediate gratification without regard to long-term consequences
- may be motivated and employed but unable to find or afford child care
- generally have not experienced success
- have emotional needs which were not met by their parents
- have low self-esteem
- have little motivation or skill to effect changes in their lives
- tend to be passive.

Characteristics of Sexually Abusive Parents

The most typical type of reported intra-familial sexual abuse occurs between an adult male, either the father or the mother's sexual partner, and a female child living in the same house. However, the perpetrator could be either the male or female in the home.

Sexually abusive parents:

- have low self-esteem
- had emotional needs which were not met by their parents
- have inadequate coping skills
- may have experienced the loss of their spouse through death or divorce
- may be experiencing over-crowding in their home
- may have marital problems causing one spouse to seek physical affection from a child rather than the other spouse (a situation the "denying" husband or wife might find acceptable)
- may abuse alcohol
- lack social and emotional contacts outside the family
- are geographically isolated
- have cultural standards which determine the degree of acceptable body contact.
- as a result of cultural and/or religious beliefs, they may act in concert either actively or passively.

The adult male:

- is often a rigid disciplinarian
- needs to be in control of the family
- is passive outside the home
- does not usually have a police record nor is he known to be involved in any public disturbance

- does not engage in social activities outside the home
- is jealous and protective of the child victim
- pays special attention to the child which usually results in sibling jealousy
- has a distorted perception of the child's role in the family
- often initiate sexual contact with the child by hugging and kissing which tends to develop over time into more caressing, genital-genital and oral-genital contacts.

The adult female:

- is frequently cognizant of the sexual abuse but consciously or subconsciously denies it
- may hesitate reporting for fear of destroying the marriage and being left on her own
- may see sexual activity within the family as preferable to extramarital affairs
- may feel that the sexual activity between the husband and daughter is a relief from her wifely sexual responsibilities and will make certain that time is available for the two to be alone
- often feels a mixture of guilt and jealousy toward her daughter.

IV

REPORTING CHILD ABUSE AND NEGLECT

Mental health professionals' involvement in the reporting of child abuse and neglect is supported by federal standards and regulations, state laws, and local policies and procedures. They authorize, encourage or mandate mental health practitioners' involvement in the reporting process by stating what is required of them and how that obligation is to be fulfilled.

Many mental health therapists have serious concerns about reporting families with whom they are working. Practitioners often feel that reporting suspected child maltreatment violates therapist-client confidentiality and may destroy trust and a future working relationship with the family.

Likewise, mental health professionals may have had previous difficulties with child protective services and may feel that because CPS staff is insufficient, untrained or lacking in adequate skills, that nothing positive will be accomplished by reporting.

These are obvious concerns which can be resolved by developing working relationships with CPS and by developing community coordination. Mental health professionals must remember that children often need protection from their parents and that a particular therapist cannot and should not take sole responsibility for the protection of the child.

STATE LAWS

Every state has child abuse and neglect reporting statutes. While each of these laws differs from the others in one or more ways, all share a common framework. In general, state reporting statutes define child abuse and neglect, specify who must report it, to whom it must be reported, and the form and content of the report. Because of the wide diversity in laws, particularly with regard to the definition of child abuse and neglect, and because of the need for accuracy, mental health practitioners should obtain a copy of their own state's reporting statute and study its provisions carefully. A review of major points contained in most laws follow.

Who Reports

Most states mandate reporting of suspected child abuse and neglect by professionals who work with or who are in contact with children. These include professionals such as social workers, psychologists, law enforcement officers and educators. Currently, most states specifically require mental health professionals to report suspected cases.

To emphasize the mandatory or required reporting of suspected child abuse and neglect, many states provide penalties for those who fail to perform their required duties under the law. Penalties can be severe: fines of up to \$1,000 and prison sentences of up to one year in some states. For those who do report, however, the law provides protection. Reporters who report suspected child abuse and neglect in good faith are immune from civil liability and criminal penalty. The reporter cannot be successfully sued for reporting child abuse and neglect to authorities, but in many states persons who are required to report and refuse to do so can be successfully sued.

What to Report

It is necessary to consult state statutes to be certain just what is considered maltreatment in a particular jurisdiction. However, most states include in their definition of child abuse and neglect some form of nonaccidental physical injury, neglect, sexual abuse, and emotional maltreatment (sometimes called emotional neglect or mental injury). One approach to defining child maltreatment is included in Chapter I.

Most states require the reporting of *suspected* child abuse and neglect; *no state requires the reporter to have proof that abuse or neglect has occurred before reporting*. The law may specify reporting of "suspected" incidents or include the phrase "reason to believe." In any case, the intent is clear: incidents are to be reported as soon as they are noticed. Waiting for proof may involve grave risk to the child. Proof may be long in coming; witnesses to child abuse and neglect are rare, and the child's testimony may be disbelieved or inadmissible. Reports are made in terms of the child's possible condition, not in terms of an accusation against parents. A report of suspected child abuse and neglect states that a child *may* be an abused child, not that the parents are child abusers. Therefore, proof is not required of the reporter. Proving the case is properly left in the hands of trained investigators.

When to Report

State statutes vary with respect to when a report must be filed. Reports may have to be made immediately, within 24 or 48 hours, or during some other specified time period. Sometimes more than one report is required, for example a written and an oral report, with each report having its own specified time period. Again, it is necessary to check state statutes to be certain which provisions apply in a given jurisdiction.

Where to Report

Each state specifies one or more agencies as recipients of reports of suspected child abuse and neglect. Usually this agency (or one of the agencies if two or more are specified) is the department of social services, human resources, or public welfare. Other agencies mandated to receive reports may include the police department, health department, county or district attorney's office, or juvenile or district court.

The local department of social services or other receiving agency may maintain a special child abuse and neglect unit, often called Child Protective Services (CPS). If there is no special unit, the local department itself will have CPS responsibility. The CPS unit receives and investigates all reports of suspected child abuse and neglect and may be involved in treatment and rehabilitation of affected families.

It is important to determine who receives reports of suspected child maltreatment in a particular jurisdiction. Requirements of confidentiality should be observed so that reports are made only to authorized persons. The state reporting statute will provide this information. An attorney should be consulted if questions arise.

How to Report

State statutes vary with regard to the form and content of reports of suspected maltreatment. Every state requires that either an oral report or a written report or both be made to the agency or agencies specified as responsible for child abuse and neglect. When two reports are required, the oral report is usually required immediately, with the written report following within 24 to 48 hours.

Some state statutes will specify just what information is to be submitted in a report of suspected child abuse and neglect. Usually this includes:

- Child's name, age and address
- Child's present location
- Parent's name and address
- Nature and extent of the injury or condition observed
- Reporter's name and location.

In some states, additional information is required. This may include evidence of previous injury to the child or to another child in the same family; any information which would aid in establishing the cause of the injury; and any information which would aid in identifying the person responsible for the injury.

To facilitate the making of an oral report of suspected child abuse and neglect, some states maintain a toll-free 24-hour telephone line just for receipt of reports of suspected maltreatment. Anyone may use this "hotline" to report an incident of suspected child abuse and neglect anywhere in the state.

Some states and local jurisdictions have developed forms to facilitate the making of written reports of suspected child abuse and neglect. These reporting forms are easy to use, ask only for required information, and include instructions regarding where they are to be sent.

Forms can greatly streamline the reporting process and should be instituted wherever possible. However, the unavailability of a reporting form does not excuse anyone from reporting; the required information need only be supplied in writing when no form is available.

The information keys on the following pages provide the mental health professional with guidelines for reporting procedures.

**INFORMATION KEY 1: Definition of Child Abuse
and Neglect**

According to laws in this state, reportable child abuse
and neglect are defined as:

INFORMATION KEY 2 : When to Report

1. An oral report ___ is/___ is not required. If an oral report is required, it must be made to the responsible agency within ___ hours.
2. A written report ___ is/___ is not required. If a written report is required, it must be made to the responsible agency within ___ hours.
3. Special requirements:

If the mental health facility has special reporting requirements, a _____

_____ (type of report) must be made to _____

_____ (name/position of person) within ___ hours.

INFORMATION KEY 3 : Where the Report Goes

Reports of suspected child abuse and neglect are made to:

Telephone Number: _____

Address: _____

Note: Fill in above the agency to which the actual report is made, regardless of who makes the report. (See Information Keys Re: When to Report and How to Report.)

INFORMATION KEY 4 : How to Report

The following information must be provided to:

(Name of person/position)

(Telephone number or address)

(If the above is a person *within* the mental health facility,
refer to the Information Key on Where the Report Goes.)

Child's name: _____ Age: _____

Address: _____

Parent's(s') name(s): _____

Address: _____

Physical indicators observed: _____

Behavioral indicators observed: _____

Other indicators observed: _____

Reporter's name and position: _____

Date of report: _____

Local Policy

Many mental health facilities are establishing policies and procedures regarding child abuse and neglect. These policies and procedures support state reporting laws and often provide internal mechanisms to be followed when a case is reported.

For example, a community mental health center may appoint a staff member(s) who would act as a liaison to the local CPS unit. The liaison's responsibilities might include making initial reports to the local CPS unit and consulting with them on situations in which the need to report is questioned.

Enacting policies and procedures is an essential step for beginning a child abuse and neglect program. They should clearly delineate the duties and responsibilities of all staff in the mental health facility.

Mental health practitioners should be aware of any policies or procedures for child abuse and neglect that exist within their agency or facility. If there are no procedures, mental health professionals can be instrumental in developing and implementing them.

DIFFICULTIES ENCOUNTERED

A report of suspected maltreatment is not an accusation. It is a request for the process of help to begin. But the reporting process does not always go smoothly. Difficulties may be encountered which can prove a bar to reporting or can discourage continued involvement in child abuse and neglect.

Personal Feelings

One of the biggest obstacles may be personal feelings. Some people just do not want to get involved; others may feel parents have the right to treat children in any way they wish. Generally, once it is understood that involvement is required and that child abuse and neglect differs from acceptable child-rearing practice, much of this reluctance disappears.

It has been pointed out that the better acquainted we are with people, the more we accept their behavior, and the harder it is for us to admit that they may have a problem. This is true in cases of suspected child abuse and neglect. It may be very difficult for a mental health professional to admit that the child of a fellow practitioner or of a neighbor has been abused or neglected. This is a natural feeling, but it must be overcome. The law does not exempt children of our friends and acquaintances from its protection.

Therapist-Client Relationship

When a mental health practitioner has established a therapeutic relationship with a parent(s) prior to recognizing abuse or neglect problems in the family, reporting becomes a delicate but necessary issue to be discussed honestly and supportively with that parent(s).

If a sense of trust has been established in the relationship, obtaining a release of information is suggested. This would make the alliance stronger and would indicate the practitioner's willingness to stand by the parent during the possible CPS investigation.

In addition, mental health professionals should encourage self-reporting by families whenever possible. This may coincide with established treatment goals of encouraging active behaviors in coping with life stresses. It may also help these parents develop trust in others by establishing new sources of emotional and environmental support.

In some states, waivers of assessment agreements between CPS and other service providers may permit the mental health practitioner who is currently providing services to the family to take primary responsibility for determining the child's safety and the validity of the report. In such cases, reporting to CPS is still required, as are subsequent advisory reports if no court intervention becomes necessary.

Problems Internal to the Mental Health Facility

Within a mental health facility, some practitioners may be reluctant to report suspected cases of child maltreatment. Although, they may feel that they can deal with the child abuse and neglect problems within their therapy sessions with the family, waiting to report may present grave risk to the child and may result in civil or criminal penalties for failure to report.

In other situations, there may be confusion within the agency or facility about responsibility for reporting. Likewise, there may be staff who do not know the signs and symptoms of child abuse and neglect and who are unaware of their legal responsibilities.

Many of these procedural difficulties can be resolved if a reporting policy is adopted, reporting procedures are instituted, and staff training is made mandatory.

Difficulties With Child Protective Services

Sometimes potential reporters become convinced that nothing will be done if they report, so they choose not to report. Aside from the legal considerations (failure to report is against the law in many

states), such reasoning is faulty. If an incident of suspected child abuse and neglect is reported, some action will occur. At the very least, a record of the report will be made, the mental health professional's legal obligation fulfilled, and the investigative process begun. On the other hand, if the incident is not reported, one may be sure that nothing will be done. Abused and neglected children cannot be protected unless they are first identified, and the key to identification is reporting.

Mental health practitioners who have had an unfortunate experience when reporting suspected child abuse and neglect may be reluctant to become involved a second time. Such practitioners may have been discouraged from reporting, or may have developed a distrust of CFS (or another agency) or its staff, feeling that a previous case was not handled to their satisfaction. These concerns are real, and often valid. Things may not have gone as well as they should have. But a previous bad experience does not mean that the next time things will not be handled well. CPS agencies throughout the country are continually working to upgrade their services. They are becoming steadily more responsive and highly skilled. Communities are providing more resources and increased staff to handle the rising number of child abuse and neglect cases. Altogether the picture is brighter than it was even a year ago, and this trend is likely to continue. However, after an unfortunate experience with the CPS agency's response, the reporter should not hesitate to request that an agency supervisor intervene in the handling of the case.

Mental health professionals must report regardless of their concerns or previous experience. The law requires it, and no exemptions are granted to those who have had a bad experience. In addition, while reporting does not guarantee that the situation will improve, not reporting guarantees that, if abuse or neglect exists, the child will continue at risk.

ASSESSMENT AND TREATMENT PLANNING

CPS, in the assessment and treatment planning process, takes a number of factors into consideration; a mental health evaluation is often one component of this process. Mental health professionals are often asked to participate in the assessment of abusive/neglectful parents and their children and to participate in the development of treatment plans for these families. It is important to remember that one of the major concerns of the mental health evaluation is the ultimate safety of the child, and the mental health professional's treatment recommendations will reflect this concern.

While the assessment, diagnosis, and treatment planning process for individuals and families is well within the capabilities of most mental health professionals, this skill is almost always related to the provision of treatment services available in that professional's own setting or in a similar milieu. Child abuse and neglect cases require assessment which not only addresses these treatment service issues but also becomes useful in two other settings which are somewhat alien if not completely unknown to the mental health professional. These settings are the child protective service (CPS) system and the court (adult and juvenile). These specialized settings have assessment needs that are not usually met in the traditional mental health diagnosis. In order for an assessment to be of use to the child protective service agency or to the court, mental health professionals must understand the case management needs of the agency requesting the evaluation, in spite of the fact that their referral questions may not be clearly stated. Diagnostic formulations and recommendations must then be tailored in such a way as to be meaningful in relation to the needs of the requesting agencies. This requires translating mental health information into the language of the court or the social service agency.

In the process of assessment, diagnosis, and treatment planning, it is the role of mental health professionals to bring into play their knowledge of family dynamics and individual development. The nature of the community's involvement in cases of child abuse and neglect often leads to a focus on an isolated abusive or neglectful incident and investigation of "victims" and "perpetrators." In order to prevent a mental health assessment from becoming an extension of such an investigation, it must add a perspective on family interactions, especially those concerning the development of children, and on ways in which family members deal with their environment. The mental health professional is the only involved individual who has the luxury of such a broad approach, for the vital job of child protection is the responsibility of the child protective service agency and the court system.

Another important issue is that the role of assessment, diagnosis, and treatment planning differs for each type of abuse and neglect. Each category--physical abuse, emotional abuse and neglect, and sexual abuse/exploitation--has a very different character and dynamic pattern and the investigation and case management of each requires that mental health professionals have specific information. For example, the kind of information needed in the case management of a physical abuse situation would differ completely from that required in a sexual abuse case. Similarly, the age of the child involved requires special consideration. The assessment of an abuse case concerning an infant would require different kinds of assessment information from that concerning the physical abuse of an adolescent.

Each of these issues acts as an underlying principle throughout this chapter, and will be taken into consideration in the following discussions of the assessment of the parent, child, and family, and of treatment planning.

ASSESSMENT OF PARENTS

Child Protective Service Assessment

Child protective services has two major functions: investigation and the provision of casework services. The mental health professional may be called on to assist in either or both of these functions or to take on a treatment role.

Assessment during the investigative phase often is accompanied by such questions as, "What is the risk to the child of leaving him/her with this parent?", "What has led this parent to abuse the child?", "What are the family's strengths and weaknesses?" and sometimes even, "Did this parent abuse the child?" Although such questions are often difficult if not impossible for the mental health professional to answer, they do reflect child protective services' need for more information as CPS workers attempt to answer these questions. Mental health professionals should not attempt to answer a question which is unanswerable on the basis of their assessment. Likewise, they should not respond to an unanswerable question by giving valid information which is irrelevant to the task of the child protective worker. The assessment should be geared to meeting the needs of CPS workers as they attempt to answer the question on their own. This can be accomplished by providing information about the parent which is presented in an understandable manner.

The Interview

The interview of abusive and neglectful parents is based on the principles and practice of all mental health evaluations. There are, however, several mitigating factors which must be taken into consideration.

- Therapists must be aware that in a high percentage of child protection cases, the client is being seen on a nonvoluntary basis. For the most part, mental health services are designed for clients who voluntarily seek assistance for a variety of symptoms. In cases of child abuse and neglect, mental health practitioners are very often faced with clients who not only *do not* want to discuss their "problems" but may not see the abuse/neglect as a behavior they want or need to change. Consequently, clients feel defensive and angry. Often their perception of the problem is much different from that of the interviewer. In most cases where clients do not see the child abuse/neglect as a problem or deny their involvement, the interviewer may be seen as a further threat. This client may also use the interview as a means of gaining the therapist's support for his/her point of view. Thus, the interviewer must be extremely skillful in focusing the interview on the issues concerning the referral without making the client so defensive that cooperation is lost. Similarly, the interviewer must avoid being manipulated into taking an unwarranted advocacy role for the client.
- The interviewer should have adequate skills in interviewing parents about their children and about the parent-child relationship. This particular information is essential to understanding the nature of the abuse or neglect problem. The developmental level of the child and the parents' reaction to that development are often vital factors contributing to child abuse and neglect. No assessment is complete without this information.
- The interviewer must keep in mind those questions pertinent to child abuse and neglect and the role of child protective services while conducting the interview. Although the interview must address the issues of psychiatric diagnosis and environmental and social stresses, it must also address the parents' ability to protect the child. At the same time, other concerns stated by the referring agency must be investigated and addressed in the assessment.
- The interviewer must not look at the evaluation in isolation, but must view the client in the context of the family. This will be discussed further in the section on family assessment.

Physical Abuse-- Special Considerations

There are special considerations which must be taken into account when assessing physically abusive parents.

- In assessing parents who physically abuse their child, a major emphasis should be placed on the parents' reaction to the physical injuries incurred.
- The family's attitude toward physical punishment and the role this may have played in the injury are also important.
- Some assessment should be made as to the ease with which these parents lose control of their behavior and how much stress is required for this to occur. Similarly, the assessment should attempt to determine what role the nonabusive spouse plays.

Neglect--Special Considerations

The following special considerations are important in assessing neglectful parents.

- In cases of neglect, it is important for the interviewer to look for those factors which have caused the parents to turn away from their children.
- A determination should be made regarding which needs of the parents interfere with their ability to nurture their children.
- Separation of environmental and psychosocial factors involved in a neglectful situation must be made before the full extent of the parents' role can be determined.

Emotional Abuse or Neglect-- Special Considerations

The special considerations which must be taken into account in assessing emotionally abusive or neglectful parents follow.

- Emotional abuse and neglect are extremely difficult concepts to define, and the mental health professional's role in the child protective service and legal process is vital.
- Most experts now agree that in order to demonstrate that parent/child interaction has been emotionally abusive

there must be an action or series of actions or omissions by the parents that can be shown to have caused emotional injury or harm. The causation and extent of injury are determinations that only a qualified mental health professional can make.

Sexual Abuse--Special Considerations

Sexual abuse is a problem which is very different in scope and etiology and which involves numerous special considerations; therefore, it cannot be addressed adequately in this manual. For detailed information concerning sexual abuse, mental health professionals are referred to *Sexual Abuse of Children: Selected Readings*, National Center on Child Abuse and Neglect (in press).

Court Assessment

There are two different types of court proceedings relevant to child abuse and neglect: the juvenile court determination regarding the status and needs of the child and the criminal court determination regarding the crime of child abuse/neglect or a related criminal charge. The psychological assessment for a juvenile court proceeding is based on the same principles as that for child protective services. Mental health professionals are much more likely to become involved in juvenile or family court hearings than in criminal court hearings. It should be noted, however, that the principles of forensic mental health prevail in the court setting.

Mental health evaluation may be used in either the adjudicatory or dispositional stage of the juvenile court process; the focus of the mental health assessment is dependent upon the type of court hearing. For example, the assessment for the adjudicatory hearing would be oriented toward past and present circumstances, while the assessment for the dispositional hearing would be more future oriented. (Information regarding these hearings will be discussed in Chapter VII.) The issues involved in the assessment of a parent for the juvenile court differ from that for child protective services only in that the evaluator becomes an agent of the court rather than an agent of the social service agency. This should not make any difference in the assessment process, because the best interests of the clients, both parent and child, are paramount to the evaluator in either case. However, it may change the parents' perception of the assessment. Especially when parents who are represented by counsel take an adversary position, an assessment ordered by the court may be seen as neutral and unbiased. On the other hand, an assessment conducted for CPS may be viewed by the parents, and their lawyer, as biased.

The same considerations discussed in the CPS assessment apply to the court assessment; there are, however, some differences.

- In some cases, clients are less apt to be defensive when interviewed for a court assessment. However, as in an assessment for CPS, the parents may distort the facts in their favor to convince the interviewer of their innocence.
- Confidentiality issues need to be clarified before the evaluation begins. For instance, the mental health professional should explain what information is relevant, to whom it will be given, and how it will be used. Clients may be counseled by their attorneys not to talk about particular issues. Therefore, lawyers and judges need to be convinced that the evaluation is meaningless without full cooperation of all parties.
- Courts often rely heavily on the evaluator's assessment and recommendations. Therefore, great pains should be taken to provide the information that the court requires to make its determinations.
- At the dispositional hearing, courts are required to make decisions which have both an immediate and long-term component. The judge needs to know "What shall I do today?" as well as "What is the best thing to do over the long run?" Evaluation should address both components.

ASSESSMENT OF CHILDREN

Child Protective Services Assessment

Mental health assessments of children are often requested by child protective services when the child is an adolescent, when emotional abuse is suspected, or when the child is exhibiting behavioral or emotional problems. However, many other abused and neglected children will require an assessment, because of the emotional consequences of child maltreatment. The questions which are usually asked of the evaluator by CPS workers focus on the role of the child in the abuse or neglect and the extent of the emotional harm to the child. This assessment is used most often to assist in treatment planning. The evaluation of the child varies most according to the age of the child. Except with the adolescent, the evaluation of the child is identical to that performed in any other assessment setting. The evaluator is asked to survey the psychosocial functioning of the children in relationship to their own development, to their family, and to the abusive

or neglectful incident. There are several basic issues to be considered in assessing any children, and there are special issues relevant to the evaluation of particular age groups.

General Concerns in the Assessment of Children

A complete history of the child's development and a family history must be obtained. The source of background information should be noted, as well as any gaps or discrepancies in information. The evaluation should place the events of the abuse or neglect and the questions posed by the referral agency in the perspective of a comprehensive evaluation. In addition, the child's current status and placement must be considered when interpreting the data from the evaluation. For example, a child who is usually able to separate appropriately may have a problem in that area when facing actual or pending separation from the family. Children who are hospitalized, in foster care, or institutionalized behave differently in that setting than the way they behave at home.

Infancy--Special Issues

The following are special issues which are related to the assessment of infants.

- Most referrals are for neglect cases where effects on development are at issue.
- Physically abused children in this age group, like neglected infants, often demonstrate developmental delays. However, these children are rarely referred to mental health clinics for assessment.
- In this age group, the degree of attachment between parent and child is a major factor in abuse and neglect and requires assessment.

Preschool--Special Issues

Mental health practitioners must address the following special issues regarding the assessment of preschool age children.

- Normal developmental tasks of this period, such as separation and toilet training, may provoke abuse/neglect.
- Problems of developmental delay are often manifested in provocative behavior such as rigidity and negativism. A problem child may also be a victim of abuse or neglect.

- Evaluation must determine whether these parents are reacting to appropriate or problematic behaviors.
- Precocious separation and hypermaturity secondary to abuse and neglect must not be mistaken for normal development and may be masking lack of depth in interpersonal relationships.

School Age--Special Issues

The following issues should be considered when assessing school age children.

- Failure to master early developmental tasks is manifest in disturbed behavior such as enuresis and refusal to attend school. Earlier traits such as negativism can still be a problem. These problems are rarely overlooked by parents and are often mentioned by them during the evaluation.
- Some developmental problems such as school failure or poor peer relations are often missed or underplayed by parents and child protective workers. However, these problems may be reflected at home in the form of cranky behavior and may play a role in abuse or neglect.
- Childhood depression, which is exhibited by various subtle means, may not be obvious. However, it is a prevalent result of child abuse and neglect and must be looked for.
- Children may defend their parents out of fear or loyalty and, as a result, may be extremely guarded and restricted in their responses.

Adolescence--Special Issues

There are special factors which mental health professionals should consider when assessing adolescents.

- Adolescents are usually more likely to report abuse or neglect than are younger children. They may report directly to child protective services, police, school, or a counselor.
- Adolescents often feel guilty about the effect of their report on their parents. They want help, but not at the expense of destroying their family or driving their parents further away from them.

- When reports of abuse or neglect of an adolescent are made by a third party, without the child's knowledge, the child is very likely to be as defensive as the parent.
- Abuse and neglect complaints by an adolescent are often indicators of other forms of family dysfunction.
- Adolescents voice their ambivalence about abuse and neglect issues by changing their minds or their stories. They may exhibit this ambivalence when they are reporting, describing abuse or neglect incidents, or discussing placement alternatives. However, the problems precipitating the report remain and should not be overlooked.
- Most adolescents who are abused and neglected have other problems which are developmentally determined and which can complicate assessment. Parents will stress these problems in their own defense, often as precipitating events for the abuse.
- When adolescents are out of control and victimize their parents, the evaluator should not forget that, whatever the provocation, the parent also lost control.
- Adolescents often see the evaluation as justified because of their "badness." They may react defensively during assessment, claiming that they are all right and their parents are at fault. The interviewer should assure the adolescent that the parents do appear to have lost control, but that he or she also appears to be having some problems that require help.

Court Assessment

The assessment of the child is relevant only in the juvenile court setting. The juvenile court is asked to make decisions based on the needs of the child. The juvenile court generally will require the same type of information as CPS, and the assessment should, therefore, be similar, if not identical. Children rarely can comprehend who has requested the evaluation and it should have no impact on their attitudes or performance.

As with parental assessments, the court-ordered assessment is viewed by parents and lawyers as more neutral and unbiased than one for child protective services. The guardian *ad litem*, the lawyer or lay person who is representing the child in court proceedings, may be the person who makes the referral, and it is this person as well as the judge to whom the report should be directed.

Although the actual assessment is similar to that for child protective services, as discussed in the preceding section, there are several important differences.

- Parents are less likely to be defensive, but often will not accept the relevance of family background to the evaluation.
- The guardian *ad litem* can be of assistance in gaining the cooperation of reluctant parents and their lawyers.
- Confidentiality and the court's use of recommendations (as discussed in the section on court-ordered assessment of parents) are applicable here.

PSYCHOLOGICAL TESTING

Psychological testing is often a useful adjunct to the mental health assessment interview in order to understand the level of functioning of the client. As with any psychological testing, it should be used to answer questions raised in the evaluation. *Psychological testing should never be used as a substitute for a clinical interview, as no test alone or in combination will provide the information necessary to aid CPS workers or the court.* Occasionally, CPS workers will require assessment of intellectual functioning; in these cases the administration of an intelligence test might be useful. However, the report on such a test should be accompanied by the full range of information garnered from the test; the mental health professional should *not* just report the score of the intelligence test.

FAMILY ASSESSMENT

The assessment of the parents and the assessment of the child have been presented separately in previous sections, because they are usually requested in that way. For example, a parent's lawyer or the court may have a question requiring mental health evaluation of a parent, or the CPS worker or guardian *ad litem* may require some information for treatment planning for the child. However, all evidence indicates that child abuse and neglect are complex problems which occur within a milieu of family dysfunction. The role of a parent or child in isolation will present a partial and often misleading picture of the situation leading to the abuse or neglect. Treatment planning from such a misleading picture may well be destructive.

Although the mental health evaluation may only involve one family member directly, all data from the assessment should be placed in the perspective of the entire family unit. Psychosocial developmental disability of a child will not lead to child maltreatment. Only when the family is comprehensively evaluated can the true role of that disability be determined. Similarly, immaturity and isolation in a parent will not, in itself, lead to child abuse and neglect. Underlying family problems resulting from individual pathologies of a parent and/or child may not lead to maltreatment until the family is compromised by some new external or internal force.

Abuse or neglect reflects a family's need. It is a symptom indicating that the family has lost, or has never attained, the ability to protect or provide for all of its members. Assessments which indicate areas of family breakdown, as well as individual problems and dynamics, will be more useful in understanding the nature of the abusive or neglectful situation and in the preparation of treatment plans than assessments which focus on the diagnosis of an isolated family member.

Thus, mental health evaluations should include:

- A conjoint family interview to evaluate family interaction. At the least this should be an interview with the parents and the abused or neglected child, if the child is old enough. Such interviews are especially important for the families of adolescents, as the joint roles of both parent and child are vital.
- The results of the assessment along with the specific individual evaluation which was requested upon referral. This should reflect the roles the various family members play in the abuse and neglect.

THE EVALUATION REPORT

The evaluation report will be used by CPS workers, lawyers, and judges. It may also be seen by the parent or an adolescent client. The report may be used as the basis for treatment planning, even if the mental health evaluator is not present at a planning meeting. The report should be written with such considerations in mind; if possible, it should not allow misinterpretation by an uninformed reader.

The report should take into consideration the information on parent assessment, child assessment, family assessment and psychological

testing, and should discuss each client who was seen by the mental health professional. The report should include the following:

- Information relating to the background of the referred client, the family, the child abuse or neglect incident, and the needs of the referral agency. This section should take into account the CPS agency's detailed social history which should be available for review by the evaluating mental health professional prior to or coincident with an assessment session.
- A description of the interview or interviews and of the data obtained, including a mental status examination. Some emphasis should be placed on any thought content pertinent to the relationship between the parents and the child and pertinent to other related issues. Great pains should be taken to avoid psychiatric jargon in the presentation of this material. An attempt should be made to use language which will be understandable to CPS workers, judges, state's attorneys, lawyers, social service administrators, and to clients. A report written specifically for a mental health audience may be completely useless and may be a disservice to other professionals involved.
- A summary and recommendations which summarize material from the background information and from the interview. Three issues should be addressed for each client interviewed: diagnosis, answers to pertinent questions regarding the abuse and neglect incident, and recommendations for mental health intervention and needs.
 - The diagnosis should be explained in a way useful to CPS workers. For example, the diagnosis of paranoid schizophrenia itself is not sufficient and must be qualified to explain how that disorder manifests itself and how it will affect the understanding of the case and the intervention.
 - In answering the referral needs of child protective services, the mental health professional should attempt to integrate the background information

and the diagnostic implications. For example, the report may state "the abuse in this case appears to be related to the parent's intolerance of the child's behavior and is not as such related to the parent's psychosis," or alternatively, "the patient's delusions involve the child in question and it appears as though the abusive incident is directly related to the parent's psychopathology."

- The recommendations should address the family as a whole as well as special needs of individuals. Further, they should take into consideration the urgency of the situation as well as the advisability of alternate solutions. For example, a recommendation of long-term psychotherapy must be supplemented with recommendations for dealing with the immediate situation before the effects of long-term therapy are realized. Similarly, a recommendation for homemaker support must be accompanied by some substitute in the event such homemaker services are not immediately available. Treatment needs which are unrelated or indirectly related to abuse or neglect must be discussed (for example, the treatment of schizophrenia in a case where that schizophrenia is not directly related to the maltreatment). However, treatment recommendations should focus on suggestions pertinent to the maltreatment, for example, "the patient's schizophrenia should receive treatment as necessary and a combined program of parent education and day care would help alleviate the abusive/neglectful situation."

TREATMENT PLANNING

Treatment planning in cases of child abuse and neglect involves two basic issues. The first of these addresses the needs of the family which must be met in order to prevent further abuse or neglect of the child. The second addresses the needs of individuals which have resulted in abuse or neglect, followed from the abuse/neglect, or are incidentally discovered during the investigation or evaluation. The mental health professional has a role in treatment planning in all cases of abuse or neglect; however, the role of mental health professionals is of primary importance in those cases where they have conducted an assessment. The mental health role is primary in treatment areas, although it may be secondary in the areas of child protection and other issues.

Treatment planning is only one part of case management, and it requires input from a variety of sources. Considerations in case management include child protection, custody, legal proceedings, and, finally, treatment. Although treatment is vital in the resolution of family and individual problems leading to abuse and neglect, child protection has an immediate component which cannot await the results of treatment. Treatment plans must mesh with the realities of these child protection needs. Once these needs are met, then treatment plans can be finalized.

Role of the Mental Health Professional in Child Protection Planning

Mental health professionals are often unable to prevent their clients' child abuse or neglect through the use of traditional techniques. Unfortunately, unless mental health professionals have specialized training and experience in child welfare, they have little expertise in the areas of child protection, juvenile court procedure, custody alternatives and placement options. Thus, their input should aim at providing information helpful to those who have expertise in these areas.

- Assessment information and mental health principles should be used to anticipate the repercussions of various protection decisions, such as risk to the child or placement alternatives.
- The mental health assessment should provide information as to effects on the family and individuals of various placement options. From this information, the CPS agency and the juvenile court can select the least detrimental alternative for the child and parent.
- Information from a mental health assessment may be helpful in determining risk to the child, especially where mental illness of a parent or child is a factor in abuse or neglect.

Role of the Mental Health Professional in Treatment Planning

Once immediate child protection needs are met, the treatment planning process can proceed. The process must include the development of plans which address several issues: placement, custody or supervision needs, problems secondary to these needs, and treatment addressing the issues revealed by the assessment. Special considerations relative to treatment plans for abusive and neglectful families include the following:

- Treatment should be a team effort, seen as a continuation of the investigation, assessment and child protection process. The various treatment needs of the family and/or members of the family must be coordinated. Treatment efforts which isolate family members or which separate service-providing agencies accentuate the type of family problems which lead to abuse and neglect.
- Case management responsibility should remain in the hands of child protective services, as long as that agency feels the child is at risk. Since many mental health professionals have not had experience with child abuse and neglect cases they may have difficulty determining risk to the child; they should accept the determination of CPS in this area.
- Traditional treatment modalities are often inappropriate for abusive parents in that these individuals require more outreach and greater levels of personal attention than are usually provided. Treatment for these parents will be discussed in the subsequent chapter.
- Various community-based treatment alternatives, such as Parents Anonymous or parent aide programs, may offer useful treatment services.

VI

TREATMENT

Mental health practitioners are an essential treatment component in the community's child protection system. They are the professionals who have the knowledge, skills and expertise to provide psychotherapeutic treatment to families experiencing abuse and neglect problems.

In fact, Title III of the Health Revenue Sharing Act of 1975 (P.L. 94-63) requires that comprehensive community mental health centers funded under the act provide the following services to the general population:

- Emergency services
- Inpatient care
- Partial hospitalization
- Outpatient care
- Rehabilitation services
- Evaluative services to courts and other agencies
- Transitional halfway house services
- Community consultation and education
- Specialized services for children, the elderly, patients discharged from mental hospitals, drug addicts and alcoholics.

SPECIAL CONSIDERATIONS

There are some special considerations which must be taken into account when treating families with abuse and neglect problems. Mental health practitioners involved in treatment for child abuse and neglect cases should be aware of the following: their own personal feelings and attitudes about child abuse and neglect, client resistance to therapy, the therapeutic relationship and outreach.

Personal Feelings and Attitudes

Mental health professionals must recognize that child maltreatment evokes intense feelings that seldom arise from other social-psychological problems. They need to assess their own personal attitudes which may impede treatment effectiveness with child abuse and neglect cases. These may include such attitudes as those concerning: the roles and responsibilities of the family in today's society; the relationship between children's, parents', and families' rights; the use of violence; child abuse and neglect; and specific abused and neglected children and their families.

Those attitudes can generally be modified by utilizing clinical supervision, by attending inservice or other training sessions which focus on child abuse and neglect and by informal and formal discussions with other professionals who specialize in child maltreatment problems.

It is important to remember that not every mental health professional is suited to deal with situations of child abuse and neglect. In those instances where practitioners believe their personal attitudes and feelings may adversely affect treatment, they should refer the family to another therapist.

Client Resistance

Traditional mental health services have required that clients be motivated to initiate and keep regular appointments usually held in the practitioner's office. However, this approach may be ineffective in providing services to most abusive and neglectful families.

Abusive and neglectful parents may be resistant to therapeutic intervention for several reasons:

- They may have serious problems in forming interpersonal relationships.
- They may distrust authorities.
- Their low self esteem may prevent them from reaching out to others.
- They frequently are not willing to admit they have a problem, and resent intrusion into their private lives. They may even go so far as to project blame for their problems onto intervening agencies.

- They frequently enter into treatment as a result of threats of possible court action or because the court has ordered them to attend therapy sessions.
- They often perceive a stigma associated with the mental health setting.

This resistance may be expressed in many different ways. For example, the parents may miss or be late for scheduled appointments; they may openly express hostility or anger toward the practitioner; they may deny any existing problems; they may talk around issues or may be nonverbal during therapy sessions.

Abusive and neglectful parents are also frequently resistant to their children receiving treatment. They may lack motivation to obtain services for their children, may openly refuse therapeutic intervention or may superficially agree to treatment for their children and then attempt to sabotage it. This resistance arises from several different parental fears or defenses:

- Denial of developmental deviations in their children. The parents may see these deviations as willful and voluntary, requiring punishment rather than therapy.
- Fear of relinquishing their special relationship with their child. The parents may fear the loss of affection and gratification from the child if a relationship with the therapist develops.
- Competition with the child for dependency gratification from the therapist and others. These parents desire to be cared for and parented even at the expense of the child's treatment.
- Fear of changes in the child's behavior and attitudes. These changes would threaten both the parents' identification with the child and the family's equilibrium.

Although most families present obstacles to therapy, these resistances are intensified in many abusive and neglectful parents. Dealing with this resistance takes a great deal of skill, flexibility and perseverance.

Of course, mental health professionals should not personalize the anger or hostility expressed. They should recognize the parents' fear and allow opportunities for expression. Abusive and neglectful parents will respond positively to sincere concern and interest

demonstrated by the therapist. Thus parental resistance can be broken down by the development of a personal as well as professional relationship. This will be discussed in further detail in subsequent sections.

Involuntary Treatment

Many mental health professionals are reluctant to work with clients who are coerced into therapy. It is true that many of these clients are unwilling to make needed changes and that court-ordered treatment initially increases their resentment and resistance. Abusive and neglectful parents who are coerced into therapy may direct their hostility toward the courts, CPS, or the therapist. Regardless of the clients' resistance, mental health professionals must ensure that clients are provided with necessary services. It is important to remember that once treatment has been ordered by the court, therapist-client confidentiality does not apply with regard to issues relating to abuse and neglect.

Although in some instances involuntary treatment may not be effective there are approaches mental health professionals can use that can encourage cooperation on the part of clients and increase their potential to change. Many of the techniques discussed in the section on client resistance can be used effectively in dealing with families who come to treatment involuntarily.

It is especially important for mental health professionals to recognize the parents' resentment and allow them to openly discuss their feelings. Practitioners should also focus on alleviating the parents' anxiety about treatment and their feelings of helplessness. One way to counteract these feelings is to involve the parents in decisions about treatment structure and goals.

A positive and caring attitude on the part of the clinician is crucial. Practitioners should indicate their concern for the family's welfare and their desire and willingness to help them live happier lives.

Therapeutic Relationship

Abusive and neglectful parents have generally suffered from serious emotional deprivation as children resulting in unmet dependency needs. They may have also experienced prolonged humiliation, criticism and rejection which inhibits them from trusting others and establishing health interpersonal relationships. Thus, in order to help abusive and neglectful parents change their unhealthy pattern of behavior toward their children, a trusting and supportive relationship must first be established.

It is necessary then for mental health professionals to focus initially on building trust by: listening, providing nurturance, being available and flexible, setting mutual goals, setting limits in a caring manner, and supporting positive strengths in the client.

Practitioners should not be judgmental or accusatory, give too much advice, develop unrealistic expectations or dwell on negative aspects rather than supporting the positive.

Outreach

Providing "outreach" is a critical part of developing an effective therapeutic relationship. Practitioners, as service providers, can demonstrate their interest, investment, flexibility and acceptance of the client in the following ways:

- Ensure that either the therapist or a back-up person is available 24 hours a day.
- Allow for flexible appointment scheduling even when many appointments have been missed. The practitioner should initiate contact with the family after broken appointments.
- Telephone the parents periodically to see how they are doing.
- Visit the family at home when appropriate.
- Provide assistance in locating needed community services.
- Help the client negotiate agency and environmental obstacles.
- Accompany the parent to court hearings, even if the practitioners' testimony is not required.

Although providing "outreach" to abusive and neglectful families requires more time and involvement on the part of the practitioner, it is extremely effective in developing the essential therapeutic relationship.

TREATMENT GOALS

The basis for most mental health treatment is the assumption that changes in perceptions, emotional responses, modes of interpersonal

relationships and ability to handle stress can be effected within the context of the therapist-client relationship.

In spite of the obstacles and difficulties presented by abusive and neglectful parents, the majority of them can respond to this type of therapy when adequate support services are provided. The treatment goals should be based on a complete assessment of the parents', children's and family's strengths and weaknesses. Treatment goals should, ideally, be developed with the participation of the family; in this way, clients feel they have some input into the goals for their treatment and are more willing to work to achieve these goals. If treatment goals are to be realistic, they must also take community resources into account.

Needs of Abused and Neglected Children

Traditionally, providing treatment for parents was believed to be necessary and sufficient to stop child maltreatment, whereas treatment for children focused primarily on alleviating physical health problems resulting from child abuse and neglect. However, abused and neglected children often experience an extremely high incidence of developmental delay and emotional disturbance. The child's behavior patterns themselves may initiate, continue or exacerbate the abuse. Thus, treatment for children is necessary not only to enhance their functioning but also to prevent abuse from recurring.

The following are typical treatment goals for abused and neglected children. Of course, particular treatment goals for individual children will be based upon the specific needs of the child.

- Establish trust in others and meet the child's developmental needs. Allow the child to experience being a child.
- Encourage individuation and the development of the capacity to tolerate separation.
- Develop a positive self-image or self-concept.
- Improve interpersonal relationships and socialization.
- Allow the child to experience positive interaction with adults and peers.
- Learn how to communicate feelings and needs verbally.
- Strengthen impulse control by channeling aggression into play.

- Develop more functional coping skills or behavior.

Needs of Abusive and Neglectful Parents

The primary goal of treatment for abusive and neglectful parents is to help them change their unhealthy pattern of behavior toward their children to one which allows them to live as a healthy, functioning family unit. This obviously requires a long term commitment on the part of the practitioner, with varying degrees of intensity over time. In order to help these parents effect needed changes, treatment goals must focus on the parents' needs.

- Develop trust in others, overcome their fear of relationships and reduce isolation.
- Develop positive self-image and the ability to nurture oneself.
- Develop support systems. Learn how to make contacts with others and how to use resources in the community.
- Learn how to communicate their needs and feelings appropriately.
- Improve impulse control and the ability to appropriately channel their aggression.
- Develop the ability to have pleasurable experiences.
- Learn how to care for the child appropriately and how to nurture the child.
- Learn appropriate and consistent child-rearing practices.

TREATMENT ALTERNATIVES

Before deciding on the method and type of treatment, the mental health professional must determine the special problems abusive and neglectful parents and their children present, their particular treatment needs, and the resources which are available within the mental health facility and the community to meet those needs.

The selection of the therapist is another important factor to consider. Mental health practitioners who are warm, caring and personal with their clients will be more effective than those who are distant and detached.

The most important factor to consider however is that abusive and neglectful parents and their children should not be treated in isolation. Whenever possible, children and parents should receive treatment together or concurrently. This maximizes the potential for positive changes in the parent-child relationship, in parental attitudes, in parenting skills, and in the child's behavior.

In situations where the parents and child are being treated by different practitioners, open communication and regular conferences are essential so that treatment issues and goals will coincide.

Treatment for Children

A variety of services for abused and neglected children have been developed to supplement casework services for the family. The intent of these services is to support the child's expression of feelings, to meet the child's emotional needs and to offer direct treatment.

The discussion of treatment alternatives for abused and neglected children in this section is not exhaustive. Other types of services exist which can be used effectively to treat these children.

Play Therapy*

Since children are less capable of expressing themselves verbally than adults, the use of play materials in a safe setting allows the child to learn to express and resolve conflicts and fears. Children as young as three and four can benefit from intensive one-to-one contact with a skilled play therapist. Play therapy can also be used as an effective diagnostic tool.

Although most abused and neglected children could benefit from play therapy, it is indicated especially for those whose conflicts are so intense that a group experience, such as a play school, will not in itself be enough to resolve their problems. Children who demonstrate low self-esteem, depression, or extreme aggressiveness towards others or who have other severe behavior management problems should be seen in play therapy.

*B.D. Schmitt and P. Beezley. "The Long-Term Management of the Child and Family in Child Abuse and Neglect," *Pediatric Annals*, V. 5, 59-78, 1976.

Group Therapy

Preadolescents and adolescents who have experienced abuse and/or neglect can benefit from group therapy. It provides them with experiences which help with socialization, self-awareness and developing sensitivity to others.

Homogeneous groups for sexually abused children and adolescents are useful in dealing with the distortion in the parent-child relationship. They also have other benefits, such as helping the children to develop healthy attitudes toward sex, to gain support from others and to gain self-acceptance.

Therapeutic Play Schools

The basic structure and design of therapeutic play schools can meet the treatment needs of abused and neglected children. These programs, by providing a safe environment, acceptance and positive feedback, can help children develop trust in others and positive self images. Consistent routines and staff predictability allow abused and neglected children to test feelings and actions. By allowing open expression of feelings such as anger and fear, children are able to recognize and deal with these prohibited feelings and channel them appropriately.

Therapeutic play schools emphasize positive interactions and relationships among peers and between children and adults rather than structured academic training. These programs are especially indicated for children between the ages of two and five who have not had other preschool experiences and who are isolated from peers.*

This type of program also gives the parents a respite from their children for a few hours each day. Parents can and should be involved in parent conferences and parent groups.

Day Care/Preschool

Traditionally day care/preschools have been intended as a service to parents, giving them freedom of movement and a respite from their child care responsibilities. Day care/preschools can provide the same kind of care in varying degrees as therapeutic play schools. One of the benefits of day care/preschools is that abused and neglected children have the opportunity to interact with adults and children

*B.D. Schmitt and P. Beezley. "The Long-Term Management of the Child and Family in Child Abuse and Neglect," *Pediatric Annals*, V. 5, 59-78, 1976.

who serve as models of appropriate interaction. For detailed information concerning the role of day care/preschool programs in child abuse and neglect prevention and treatment programs, mental health practitioners are referred to another manual in this series entitled *Early Childhood Programs: The Role of Day Care, Preschools and Head Start in the Prevention and Treatment of Child Abuse and Neglect*.

Foster Care

Foster home care is designed to provide children with a safe and stable home environment in which their physical needs are met. It should be used for abused and neglected children on a short term crisis basis when it has been determined that the child would be in imminent danger if he/she remained at home. Sometimes professionals believe that a particular child would be better off in an alternative living arrangement. However, foster care placement should be used as a last resort because of the serious disruption to the family unit and the emotional cost to the child.

Unfortunately, most foster care programs do not meet the needs of abused and neglected children. Some of the problems with foster care are: many children drift into longer term foster care than is initially intended, many children are moved from one foster home to another, screening procedures for foster homes are not selective enough, and foster parents do not receive adequate specialized training or ongoing professional supervision. These conditions should be remedied if foster care is to be more therapeutic for the child.

When mental health professionals are treating a child who is currently in foster care, they should be involved with the foster parent in order to ensure that a therapeutic environment is provided. In fact, foster parents should be treated as colleagues. The natural parents should also be included in the treatment process in order to facilitate the child's reentry into the family.

For detailed information concerning foster care and permanent planning, mental health professionals are referred to *Permanent Planning for Children in Foster Care: A Handbook for Social Workers*, DHEW Publication No. (OHDS) 77-30124.

Group Homes

Many local departments of public welfare or social services operate group homes as an alternative to traditional foster care situations. Group homes are usually operated in a single family dwelling and are

*R.S. Kemp and C.H. Kempe. *Child Abuse. The Developing Child*, Cambridge: Harvard University Press, 1978.

an integral part of a neighborhood. Regulations for group homes vary from state to state, but they are geared toward preadolescents and adolescents. There may be as few as four and as many as twelve children in each group home.

Group homes are most beneficial to children who need structured peer group interactions and a group living situation. They may be children who failed to adjust to a traditional foster home setting or who exhibit acting out behaviors. Some group homes have the capacity to provide individualized care and services to these children, and to their parents where appropriate, in order to enhance the family's ability to function in the community. Many group homes do not have the capacity to provide treatment other than what is available in the community.

It is important to coordinate treatment efforts with the natural parents in order to aid the child in reentering the family.

Residential Institutions

Residential child care facilities differ from group homes in that they provide a more institutionalized setting. Children usually live and attend school in a campus-type environment. These facilities have the advantage of employing a resident team of professionals, including a therapist, who can be supportive of each other and of the children. Residential facilities are usually aimed at treating severely disturbed children. The structure of the residential program allows for effective management of provocative and destructive behaviors and of difficult peer and adult interactions.

Adoptions

Adoptive services for abused and neglected children are provided in those situations where the parents voluntarily relinquish custody of their children or where the courts terminate parental rights because the parents have been found to be incapable of providing adequate child care. In some situations it is preferable for the child to be either adopted by relatives or by foster parents who have cared for the child for a period of time.

Supportive Services

Supportive services should be used as an adjunctive service for abused and neglected children who are receiving various forms of treatment. Those children who are not manifesting difficulties which require therapy could also benefit from these services.

Services such as Big Brothers, Big Sisters, and foster grandparents can provide abused and neglected children with a consistent role model, support, and nurturance. These individuals can engage in activities with children and help them become involved in recreational and social programs which reduce isolation and increase the child's social skills.

Church and community activities can also be beneficial to some children experiencing abuse and neglect problems. These programs can provide support to the child, help overcome problems of isolation, and broaden the child's range of social contacts. Programs such as these exist in most communities. Prior to referring a child to a specific program, mental health professionals should determine whether it would meet the child's needs, whether the program leader is responsive to the child's problems, and whether the child is appropriate for the program.

In situations where supportive services are utilized, it is necessary for the clinician to provide consultation to and maintain ongoing communication with those service providers.

Treatment for Parents

Various types of therapy have been used to treat abusive and neglectful parents; each has advantages and limitations. Regardless of the method chosen, it is generally necessary to involve more than one person and more than one service to effectively treat abusive and neglectful parents. It is important to remember, however, that involving too many professionals and/or too many services can overwhelm a family and increase their feelings of helplessness and powerlessness. Whatever type of treatment is used, it must take into account the parents' need for love, acceptance and approval.

Individual Therapy

The design of individual therapy can be beneficial to abusive and neglectful parents because it provides the parent with individual attention and recognition. Treatment goals should be specific and should focus on immediate problems. In determining treatment goals, the therapist must consider the parents' present situation, their ability to verbalize feelings, their ability to make changes and draw on external supports. One example of an appropriate treatment goal might be to improve the parents' ability to interact with other adults. This will allow the parents to rely on other adults rather than on children for personal support. Another goal might be to

assist the parents in learning to manage the practical aspects of their lives. Treatment could also be concentrated on changing one type of behavior; for example, parents whose only contact with their children is for disciplinary purposes might concentrate on providing their children with positive types of attention and reinforcement.*

Once immediate treatment goals have been met and a relationship has been established, the parent may be able and willing to deal with deep-seated problems, such as their unmet dependency needs or anger they feel toward their own parents. It is important to remember that dealing with these long-standing problems takes a great deal of time and patience and not all parents are in a position to resolve them.

Marital and Family Therapy

Marital therapy is beneficial especially in those cases where parents are aware that anger and frustration from their marriage is being vented on children. Parents can learn how to express their feelings to each other and to listen and respond openly. Because of the increased communication and gratification within their marriage, parents will be less likely to abuse their children.

Marital therapy is contraindicated in cases where the parents are very dependent and emotionally needy; they are likely to compete for the therapist's attention and will probably not accomplish much.

Family therapy can also be a constructive approach if the family members are sufficiently articulate, the children are old enough, and the level of anger is not too high. The same warning applies to family therapy, however; the individual needs of family members must be met before beginning family therapy in order to avoid competition for the therapist's attention.

Group Therapy

Group therapy may be used as an adjunct to other types of treatment for abusive and neglectful parents, but is seldom adequate when used alone. Group therapy has numerous advantages for parents experiencing abuse and neglect problems:

- It helps to reduce isolation by bringing the parents into contact with others.
- It helps to improve self-esteem by providing the parents with the opportunity to find out that others are experiencing similar difficulties. Within the group setting, parents can offer suggestions to others for coping with or solving problems.

*R.S. Kempe and C.H. Kempe. *Child Abuse. The Developing Child*, Cambridge: Harvard University Press, 1978.

- It can help parents learn to trust others. It provides an atmosphere where mutual support can develop within and outside the group.
- It can create an atmosphere where peer confrontation of denial, projection and rationalization can occur. Confrontation usually takes place more quickly and more intensely in group therapy than in individual therapy.

Group therapy is appropriate for parents who are not severely disturbed, who are not extremely threatened by expressing their feelings, attitudes and problems to others and who are capable of verbal expression. Mental health professionals should conduct individual sessions with these parents before they become involved in group treatment. This allows the parent to develop an alliance with the therapist, and reduces the likelihood of missed sessions and premature termination.

Residential Family Therapy

Residential family therapy is a relatively new and rare treatment modality in which the entire family moves into a treatment facility for several months. It is used as an alternative to foster care placement.

This type of treatment can provide intensive therapy to both parents and children and provides each family member with nurturance and support. In addition the staff focuses on improving the parent-child relationship by modeling and teaching appropriate and consistent child rearing techniques.

Parent Education

Parent education, using cognitive and affective learning techniques, enables abusive and neglectful parents to develop adequate parental attitudes and skills. Affective education helps parents learn to recognize their own feelings, to communicate those feelings effectively, and to understand what others are feeling. In most cases, affective education must be provided prior to or simultaneously with cognitive parent education if the latter is to be effective. Cognitive components of parent education attempt to impart the following:

- Information regarding child development--age appropriate behavior and needs.
- Information regarding discipline--establishing clear and fair family rules, age appropriate limits, and appropriate and consistent disciplines.

- Information regarding the child's emotional growth -- the child's need for nurturance and affirmation.

Education in parenting can be provided by the child protection worker, a visiting health nurse, a mental health professional or a parents' group.

Most abusive and neglectful parents can benefit from this type of instruction, but it should not be the exclusive treatment method for the majority of parents. Parents who severely abuse their children, who use physical punishment on young infants, and who defend the right to use harsh discipline are usually suffering from more severe emotional deficits. Due to their extreme emotional needs, these parents may hear but be unable to use information about parenting. Thus, it is important for these parents to establish a relationship with a therapist and show progress in therapy prior to receiving parent education. Other parents, such as some neglectful parents, can benefit from instruction in parenting techniques without having received other types of treatment.

Supportive Services

Since abusive and neglectful families have many problems, more than one type of treatment or service is needed to improve their level of functioning. Supportive services, such as the use of community health nurses, homemakers, parent aides and crisis nurseries, can meet the needs of these families.

Mental health professionals, in conjunction with CPS, should determine which services can meet the needs of these families and which community agencies can provide the needed services. With any supportive services, including the following, consultation, supervision, and ongoing communication are required to ensure that the services are effective for the family.

Community Health Nurses: Community health nurses are an invaluable treatment resource in dealing with the problem of child abuse and neglect. Community nurse services exist in most communities. These nurses are often seen as nonthreatening professionals and can thus gain entrance to homes where no one else is accepted. They can provide in-home care for medical and nonmedical problems.

Community health nurses have the capacity to develop a therapeutic relationship with abusive and neglectful parents. In addition to providing medical services, community health nurses can provide assistance in child care needs and can help to improve the parent-child relationship by offering suggestions and modeling "good parenting."

Community health nurses can be used effectively in situations where a child has been diagnosed as failure to thrive, where the child has repeated accidents, developmental delays or any related medical problems. Actually, any abused or neglected preschool child could benefit from community nurse services.

Homemaker Services: Homemaker services have been used in a variety of ways in treating families experiencing abuse and neglect problems. In some communities, homemakers have moved in temporarily with families experiencing stress, thus providing an alternative to removing the child.

Homemakers are used primarily to help parents with home management and child care. They can be trained to provide parents with understanding and emotional support.

Homemaker services are contraindicated in abusive situations where homemakers would be of no help in changing very destructive patterns of behavior.

Parent Aides: Parent aides or lay therapists are paraprofessionals who work, sometimes on a voluntary basis, with abusing and neglecting parents. Parent aides become intensely involved with abusive or neglectful parents for a period of 12 to 24 months. Their focus is on providing the parent with warmth, understanding, support and a listening ear. Once a trusting relationship has been established, it can be used as a vehicle for resolving family problems.

Parent aides can work effectively with abusive and neglectful parents who are isolated, emotionally immature, crisis ridden, or who have low self-esteem. Parent aides should not be used in situations where the parents are severely disturbed, volatile, or in situations where the parents are suffering from substance abuse.

Parent aides must be carefully screened, trained and supervised. This type of program is a cost-effective means of providing treatment to abusive and neglectful families. Mental health professionals can be instrumental in developing and implementing such a program in their community.

For detailed information concerning the development and implementation of parent aide programs, mental health professionals should refer to another manual in this series entitled, *Parent Aides: Program Development and Implementation*.

Parent Anonymous: Parents Anonymous is an effective self-help organization with chapters in every state. It emphasizes peer support and assistance. Parents who have experienced stress and anger that can lead to abuse can attend weeeekly meetings where they share experiences and feelings in a noncritical, supportive atmosphere. Parents Anonymous also provides these parents with support outside group meetings. Members exchange first names and telephone numbers and are available to each other during times of stress, regardless of the hour.

P.A. groups have a professional sponsor who is knowledgeable about child abuse and neglect. The sponsors attend weekly meetings and serve as facilitators, and provide assistance in crisis situations. Individual mental health practitioners who have a special interest in child maltreatment can serve as sponsors for P.A. groups.

Crisis Nurseries: Crisis nurseries offer immediate relief to parents who are temporarily unable to care for their children. Their primary functions are to protect the child and help stabilize the home situation by providing parents with a respite from child care responsibilities. In addition, they can provide therapeutic experiences for the child.

Crisis nurseries operate 24 hours a day and are especially useful to parents who are able to recognize potential crises and who are able to reach out for help.

Employment and Training Programs: Many abusive and neglectful parents, if so motivated, can benefit from employment and training programs. Learning a marketable skill and becoming employed can help improve the parents' self-esteem. Resources exist within most communities which can provide these services, such as the Work Incentive Programs (WIN) obtained through the local department of public welfare, state vocational rehabilitation services, and Comprehensive Employment and Training Act Programs (CETA).

VII

THE MENTAL HEALTH PROFESSIONAL'S INVOLVEMENT WITH THE COURTS

Mental health professionals may be required to appear in court regarding mental health issues for a number of reasons: sanity or competency hearings related to civil or criminal matters; drug or alcohol abuse matters; juvenile delinquency matters; child custody issues in divorce courts; and child abuse and neglect cases. While many of the court proceedings and the preparations for mental health testimony are similar in these various proceedings, child abuse and neglect deserves special attention.

Involvement with the court may occur at any point in the CPS response process. Court intervention may be required in cases where families refuse to cooperate with the investigation; families are unwilling to accept needed services and the child is in substantial danger; the investigation indicates the need for removal of the child; the family is only eligible for services if the child is a dependent of the court; the family is already under the authority of the court and a modification of the court order is necessary; it is necessary to terminate the parental rights of the natural parents. Since mental health practitioners may be involved in child abuse and neglect court proceedings, they should be familiar with the court system.

CHILD ABUSE AND NEGLECT AND THE COURTS

There are two types of laws dealing with child abuse and neglect, criminal and civil. Some states have criminal laws specifically making child abuse and neglect a crime. Others prosecute child abuse and neglect under broader criminal statutes, such as assault, battery, rape or homicide.

Juvenile or family court laws are specifically created to deal with legal problems related to minors. Child abuse and neglect or dependency cases are one type of case covered under juvenile court laws. In addition, these laws usually contain definitions of child abuse and neglect. Child abuse and neglect cases are more likely to be referred to juvenile than to criminal courts.

Criminal courts, when they do handle child abuse and neglect cases, are authorized to determine the guilt or innocence of the accused and to sentence the accused, but they have no authority over the child victim of the abuse and/or neglect.

The juvenile or family court approach to the problem focuses on the child's need for protection and on providing any help and services to the parents that are necessary so that they can adequately care for the child. The court may terminate the parent-child relationship only after the parents prove to be unable to provide for the child. Thus, the juvenile court's function is to protect the child from further injury while working closely with social service professionals to treat the child and the family. Because the court has jurisdiction over minors and takes jurisdiction over any abused or neglected child, it has authority over the physical custody of the child. At the same time, it is the court's responsibility to ensure that the legal rights of the parents and child are protected.

There are a number of possible types of juvenile court hearings, which include:

- Protective custody and removal hearings. In emergency situations where there is imminent danger to the child if the child remains with the parent(s), the child may be removed from the custody of the parent(s) and placed in protective custody. This decision may be made by the police, juvenile probation, the juvenile court, child protective services and/or a physician, depending on state laws. Wherever a child is placed in protective custody, a petition must be filed in juvenile court, usually within 24 to 48 hours, and a hearing must be held soon thereafter.
- Adjudicatory hearings. An adjudicatory hearing is the evidentiary or fact-finding trial in which the state must prove to a judge that the child is abused or neglected. Unless the parent(s) admits that he/she has neglected or abused the child, it will be necessary to call witnesses to determine whether abuse/neglect is occurring. Because the hearing is civil rather than criminal the state need not prove abuse or neglect *beyond a reasonable doubt*, but only by a *preponderance of the evidence*, except where state statute specifies otherwise.
- Dispositional hearings. A dispositional hearing may occur on the same day as the adjudicatory hearing or may be held on a separate day, sometimes weeks later. The purpose of this hearing is to determine what should be done to alleviate the child abuse or neglect problems. The evidence presented at the dispositional hearing focuses on the ability of the family to care for the child and on the recommendations of the CPS

agency and perhaps of other involved professionals as to the appropriate treatment for the family and appropriate placement for the child.

- Periodic reviews. Review hearings are held after the dispositional hearing. Their purpose is to measure the progress of the case and determine any need to modify the previous court order.
- Termination hearing. A termination hearing determines whether parental rights should be terminated and the child placed for adoption.

TESTIMONY

Most states require mental health professionals to give testimony regarding suspected child abuse and neglect when they are subpoenaed by the court at the request of one of the attorneys involved. Client/therapist information regarding alleged child abuse and neglect is not privileged or immune from questioning during sworn testimony. In these situations mental health professionals are immune from civil liability. Therefore, when practitioners become involved in child abuse and neglect proceedings concerning families they are treating, they must be capable of discussing issues of confidentiality and must attempt to maintain the therapeutic alliance. Likewise, in situations where practitioners evaluate families as part of child abuse and neglect proceedings, they must inform the family of their role and legal responsibilities.

In most states, direct statutory language regarding reporting and court testimony is designed to protect children subject to child abuse and/or neglect; thus these statutes abrogate certain rights of privileged conversation, such as that between therapist and client or husband and wife. To ascertain which privileges can and which cannot be claimed, it is essential to refer to the state's statutory exceptions and case law.

Expert Witnesses

Although mental health practitioners may be required to testify at any type of court proceeding, they are more likely to be involved in adjudicatory and dispositional hearings. It is often at the adjudicatory hearing that mental health professionals are asked to testify as to their contact with a family, their evaluations and their findings.

Mental health practitioners can testify regarding their professional conclusions based on their evaluations of parents or children only if they are recognized by the court as expert witnesses. In order for mental health practitioners to be qualified as expert witnesses, they must first be questioned as to their education, training, job experience and/or writing in the field of expertise. The opposing attorney can then cross examine the witness and may attempt to cast doubts on the witness's expertise through questioning. Once the witness's qualifications to offer expert opinions have been established, the witness's conclusions may be offered into testimony.

Guidelines for Testifying in Court

The best preparation for court is a clearly written report of what mental health professionals have seen and heard, their opinions, findings and recommendations. It is important to reread the case record before testifying.

Mental health professionals have the right to request a prehearing conference with the CPS agency and the attorneys who represent the child and CPS. Such a conference can familiarize practitioners with the circumstances of the case, court room procedures, and questions they may be asked. Some guidelines for effective testimony are:

- A witness's manner of dress, tone of voice and facial expression all contribute to the judge's perceptions of the testimony. A mental health professional who antagonizes the judge or any of the attorneys may prejudice the case and may be held in contempt of the court. It is very important, therefore, to avoid being argumentative.
- The practitioner should answer only the question asked and should not volunteer additional information. It is important for the witness to understand the question asked and not to guess at an answer. All statements must be as accurate as possible. The mental health professional should take time to think both the question and the answer through thoroughly before responding. If a yes or no answer is requested, but cannot be accurately given, the practitioner should explain that this would be a misleading response and that the question cannot be answered in that way. Usually the witness will be given an opportunity to explain the response more completely. Remember that witnesses have rights too. Help can be requested in the form of a question to the judge if the witness feels the answer being sought would be misleading or untrue.

- Mental health professionals should avoid using professional jargon. Their testimony should be in terms understandable to the layman. If it is necessary to use diagnostic labels, the practitioner should provide an explanation.
- Mental health professionals may be permitted to refer to notes during testimony.
- During cross-examination, the opposing attorney may try to confuse the practitioner in order to make the testimony appear inaccurate or biased. The witness should never respond to this angrily or in haste, but should remain calm and answer the question as clearly and accurately as possible. If a witness becomes flustered, it is possible that inaccurate or misleading information may be given, and the best interests of the child may not be served. Ask the judge for help if the questions or manner of an attorney are confusing.

VIII

SUPPORT OF THE CHILD PROTECTION SYSTEM

Child Protective Services is usually the agency with the legal mandate to intervene in child abuse and neglect cases. CPS, however, cannot and should not have total responsibility for the treatment and prevention of child maltreatment. Each professional and community agency has a role in the child protection system. The critical role that mental health professionals play has been discussed in previous chapters.

A coordinated community effort is required to support CPS and to provide effective services to families with child abuse and neglect problems. To achieve this, community agencies need to develop agency policies and procedures for dealing with cases of child maltreatment, to establish interagency coordination, to support and participate on community multidisciplinary case consultation teams, and to participate in their community's child protection coordinating committee.

In order to fulfill their community responsibilities, mental health professionals should develop a working relationship with CPS. Since practitioners play an integral part in the child protection system, they must coordinate their efforts through CPS.

DEVELOPMENT OF AGENCY CAPABILITIES

A crucial step in effective service delivery and in community coordination, is the development of an agency capability to provide services to families with child abuse and neglect problems. This requires the establishment of agency policies and procedures, staff development and training, and in large agencies or those serving large catchment areas, a specialized child abuse and neglect unit.

Policies and Procedures

It is essential for mental health facilities to assess their policies and procedures and to modify any which may impede mental health service delivery to abusive and neglectful families.

The following policies and procedures should be established to effectively treat families with abuse and neglect problems.

- Flexible appointment scheduling
- Follow-up on missed appointments

- Outreach and home visits
- Involvement with the family's environmental situation
- Specified staff available on a 24 hour basis.

Staff Training

Training is necessary if mental health professionals are to identify cases of child maltreatment and provide evaluative and treatment services. Training programs should stress identification, reporting, treatment and prevention of child abuse and neglect; furnish information on the practitioner's role in the child protection system, and offer opportunities for discussion of problems and concerns.

If no such inservice training programs exist within the mental health facility, individual practitioners can be instrumental in initiating them. They can draw upon the expertise of other professionals within the community, such as CPS workers.

Specialized Child Abuse and Neglect Unit

Many mental health centers are designating staff who have an expertise in the area of child maltreatment to evaluate and treat those families experiencing child abuse and neglect problems. This unit could also provide specialized child abuse and neglect training and consultation to other staff.

DEVELOPMENT OF AN INTERAGENCY NETWORK

Cooperative efforts between mental health facilities and practitioners and other community agencies, especially child protective services, are required to treat and prevent child abuse and neglect and to avoid duplication of services. An example of a qualified service organization agreement is included in Appendix B.

Mental health professionals may be involved in preventing the recurrence of child maltreatment in a particular family when they report suspected child abuse and neglect. By filing a report, practitioners begin the helping process that will ultimately provide protection for the child and assistance to the family. Informal and formal communication and coordination with child protective services will facilitate this process. If mental health professionals are acquainted with CPS workers and understand their responsibilities, they are more likely to feel comfortable discussing suspected child maltreatment cases.

After the family has been reported, the mental health practitioner may become or remain the primary service provider, while CPS plays a monitoring role.

In many instances, there are several professionals or community agencies involved with a particular family. Providing treatment in these cases requires open communication and good coordination among the service providers. To achieve coordination it is beneficial to:

- Appoint a staff member(s) who would serve as a liaison between the mental health center and CPS
- Initiate joint inservice training programs through which professionals can become personally acquainted and familiar with each other's work functions
- Establish ongoing case conferences involving all of the professionals assigned to a particular case.

Liaisons

An effective way to establish interagency coordination is through the selection of a staff member or team to act as liaisons between agencies. If the mental health facility has established a specialized child abuse and neglect unit, some staff who are assigned to that unit could be selected as liaisons. These liaisons can perform the following functions:

- Coordinate incoming and outgoing child abuse and neglect referrals
- Handle intra- and interagency difficulties regarding child abuse and neglect cases
- Initiate intra- and interagency inservice training programs
- Increase community awareness of their agency's capability in responding to child abuse and neglect
- Initiate new child maltreatment programs or services within their agency.

Consultation

Because of their knowledge and skills, mental health professionals can provide consultation to CPS in the assessment process and

treatment planning. This can be done informally, on a case-by-case basis. Alternatively, mental health professionals could meet with CPS on a regular basis to discuss cases and to provide input on diagnostic and treatment issues.

PARTICIPATION IN AND SUPPORT OF CHILD ABUSE AND NEGLECT MULTIDISCIPLINARY TEAMS

A community approach to child abuse and neglect is most effective because it makes optimal use of the special skills and knowledge of various professionals so that family and community needs are met. Many communities are turning to multidisciplinary child abuse and neglect case consultation teams as a means of assuring integrated planning and service delivery. Case consultation teams usually include representatives from health/mental health, social services, law enforcement, and education agencies. Members bring with them a wide range of backgrounds and a diversity of diagnostic, assessment, and treatment skills. They meet together regularly to assess cases of child abuse and neglect and to recommend treatment programs. Team members are able to commit services from the agencies they represent, and together they are able to call upon a broad range of services, resources, skills, and programs to help families at risk.

In addition, child abuse and neglect case consultation teams frequently serve as a forum for resolving the issues and conflicts that inevitably arise whenever difficult social problems must be addressed by multiple public and private agencies. As they work together, team members come to know, to understand, and to appreciate each other's functions in the management process. Within the team framework, if problems arise, they can be quickly solved. If a particular recommendation has not proven effective, another can be considered. Lines of communication are opened and the entire process works more smoothly.

Mental health professionals are essential participants on case consultation teams. They can lend their expertise in the area of diagnosing and treating emotional problems.

COMMUNITY COORDINATION

In order to aid community coordination, some communities are establishing child protection committees or task forces. The purpose of a child protection coordinating committee is to provide an organizational structure in which community agencies and resources that are involved in meeting the needs of children and families can work together to achieve that objective through defining roles and responsibilities, increasing communication and coordination, identifying

gaps in services and avoiding duplication of services while increasing the efficient and effective utilization of existing services and resources. Although, in most instances, CPS has the primary responsibility for organizing the committee, the mental health professional is one of many persons from multiple agencies and professional disciplines who must work together to maximize the opportunities for the optimal development of the children within the community. If there is no child protection coordinating committee within a community, mental health professionals may be able to help institute such a coordinating body.

Obstacles to Coordination

There are a number of obstacles to be avoided in order to ensure successful coordination of the committee resulting in effective service delivery.

Turfism

"Turfism" or feelings of territoriality must be prevented among professionals involved in the child protection system in order to coordinate service delivery effectively. Open communications and an understanding of mutual goals among community agencies and professional groups would decrease these attitudes.

Differences in Priorities

Although community agencies and professionals are concerned about the same problem, child maltreatment, they may approach it from different perspectives which would result in differences in priorities.

To ensure a unified sense of purpose or direction, overall goals of the committee should be decided upon at the outset. Once the goals have been determined, clearly defined objectives should be established and put in writing.

Differences in Professional Judgment

There are bound to be disagreements about decisions among committee members. Since members are working toward the same end, differences of opinions can be honestly and openly discussed and compromises reached through negotiation. Mental health professionals and other committee members can assist in this process by being receptive to opinions and suggestions that differ from their own.

IX

PREVENTION

While reporting child abuse and neglect and improving services to families is an effective means of preventing child maltreatment from recurring, the major thrust of prevention is to stop child abuse and neglect from occurring at all. Efforts to prevent child maltreatment require a well coordinated community effort, an effective service delivery system, and appropriately focused attitudes and priorities within the community if they are to be successful. Mental health professionals have a vital role in the prevention of child maltreatment through mental health based programs, mental health-community programs and individual action.

MENTAL HEALTH BASED PROGRAMS

Preventive programs may include: resource centers where family members can receive informal counseling, parent education programs, programs designed to teach coping skills, and programs to assist families at risk. Many of these services already exist within the community mental health system, but they may need to be expanded or altered for use by the general public.

Outreach

Families who would benefit most from prevention efforts generally require programs that reach out to them. In order to help these families make use of available resources, mental health centers could establish an outreach program in which staff would go into the community and visit families in their homes. During these visits, mental health professionals can establish a rapport with families and use gentle persuasion to encourage their participation in available programs. Another means of reaching these families is through media coverage. Television, radio, newspapers and flyers can provide program information to families who may not seek out help on their own.

Family Life Resource Center

A family life resource center is a new but viable option for preventing child abuse and neglect. This type of center can be a resource for all families--individuals who are planning to have children, those who are not presently experiencing difficulties with their children and those who are having problems with their children.

These resource centers can provide the community with informal child guidance services through counseling, support and educational groups. The center should be staffed by mental health professionals, but should have its own identity rather than being affiliated with mental health centers or child protective services. This would allow services to be provided in a nonthreatening atmosphere and would avoid the type of stigma sometimes associated with other agencies.

These centers could be as accessible as public libraries, schools, and churches and can be housed in any of these facilities. The development of this type of center requires initiative and commitment on the part of either an individual or group of mental health professionals.

Parent Education

One approach to preventing child abuse and neglect is to provide education for parenthood programs for the general public. Some cases of child maltreatment have been associated with a lack of knowledge about children's needs and development. By making such information more widely available, it is possible to reduce the incidence of child abuse and neglect. Education for parenthood programs stress the skills required of a parent, suggest ways to strengthen family life, and address such topics as nutrition, consumer affairs, family planning, and household budgeting. These programs would also cover child development, parent-child communication skills, and appropriate and consistent discipline.

Education in Coping Skills

Stress is usually the precipitating factor in child abuse and neglect. Lack of successful coping skills, a reduced ability to ask for and accept help, and a low level of self-sufficiency have been cited as characteristics common among abusive and neglectful parents. Education in coping skills would focus on improving peoples' self-sufficiency and ability to handle stress. These courses would help people to:

- Be aware of the effects of stress
- Recognize signs of stress in their own lives
- Develop ways of dealing effectively with stress
- Gain help or support when under stress

- Recognize feelings of anger, frustration and fear and express these feelings appropriately
- Nurture themselves and gain support and nurturance from others.

This information can be provided through courses, peer groups, and couples' groups. This type of training could take place in one session, could be time-limited, or could be available on an ongoing basis. Mental health practitioners are the professionals in each community with the knowledge and skills to provide this service. Again, mental health professionals will need to expand current services, coordinate their efforts with other agencies, and provide these services through a variety of organizations.

Emotional Bonding Programs

Programs that encourage emotional bonding of parents and siblings to infants are effective preventive techniques. Mental health professionals, because of their knowledge of emotional bonding, could coordinate with hospital personnel to provide training for nurses, aides, and other staff who have contact with mothers and infants. Hospitals can provide special aides who are available to encourage positive bonding between every mother and newborn; this can provide mothers and babies with more concentrated attention than is available from busy nursing personnel.

Hospital staff should encourage both parents to have physical contact with their baby within a short time after delivery. The parents' contact with the baby should continue through hospitalization. If the baby must remain in the nursery for some medical reason, hospital staff should encourage the parents to participate in caring for the child in the nursery.

Help for Families at Risk

Mental health professionals can aid in the community effort to prevent child abuse and neglect by recognizing and offering assistance to families at risk. Identifying families with potential parent-child problems necessitates the development of screening methods. Families who have the potential to become abusive or neglectful are usually under a great deal of stress; for example, adolescent parents, couples who are anxious about child care, couples who have financial or domestic problems, drug- or alcohol-dependent parents, or parents who have mental or physical problems.

When an at risk family has been identified, supportive services should be made available to them, not in an accusatory fashion, but just to

relieve some of the stress in the home. Such services may include day care, homemaker services, crisis hotlines and support or self-help groups.

Crisis Hotlines

Many large communities have 24 hour crisis hotlines which provide supportive counseling as well as referral services. These hotlines can be staffed by well trained and supervised volunteers. Mental health professionals can assist in the establishment of these hotlines and in the training and supervision of the telephone counselors.

Support or Self-Help Groups

Support or self-help groups can provide needed assistance to families experiencing stress. These groups provide parents with peer support within and outside the group. In addition, parents can freely express their feelings, concerns and problems and obtain suggestions for alternative behaviors. Parents Anonymous is an example of such a self-help group. Mental health centers can sponsor these support groups and individual practitioners can act as group facilitators.

MENTAL HEALTH-COMMUNITY PROGRAMS

Traditionally, mental health professionals have been advocates in their communities for public awareness of mental health issues and services. They have also assumed a primary role in advocating for treatment in special problem areas such as substance abuse. Thus, they are logical participants in community efforts to prevent child maltreatment.

Training and Staff Development Programs

Training and staff development for all who work with children is a starting point for a cooperative community effort. These programs should stress identification, reporting, treatment and prevention of child maltreatment, furnish information on professional roles and responsibilities in case management, and offer opportunities for free and frank discussion of mutual interests and problems among professionals in various disciplines. Mental health professionals can play an important part in staff development and training. They can transmit to others a knowledge of the nature and dynamics of emotional problems as well as therapeutic knowledge and skills.

Public Awareness Programs

Mental health centers and practitioners can also participate in public awareness programs. By increasing public sensitivity to child abuse and neglect, mental health professionals can help to develop a cadre of concerned individuals who will press for needed resources, programs and funding for prevention of child maltreatment.

Use of Mental Health Facilities and Resources

Mental health centers can offer concrete help in child abuse and neglect prevention efforts by making their facilities available. Meeting space can be provided for self-help groups, and mental health centers can sponsor public forums and workshops on child abuse and neglect.

Joint mental health-community education programs can be offered. Mental health professionals can coordinate their efforts with health care agencies and schools to offer discussions on child development and alternative means of discipline. Mental health professionals can serve as consultants, leaders or facilitators for these programs.

INDIVIDUAL ACTION

Individual mental health practitioners also have a role in preventing child abuse and neglect. They may be involved in preventing a recurrence of child maltreatment in a particular family, or they may be involved in broad based community efforts aimed at primary prevention.

Mental health professionals can advocate for changes in neighborhood groups and organizations, developing interrelationships which are supportive of family life and which prevent isolation. A block parent system can be initiated so as to reestablish the "neighborly" attitudes that are rare in modern neighborhoods. Also, neighborhood centers where families can go to socialize or to receive services, can be encouraged.

In addition, individual practitioners as members of their respective communities belong to a variety of groups outside of their jobs and can use these voluntary associations, when feasible, as a forum for promoting community awareness of the problems and issues involved with the prevention of child maltreatment. They can work with these groups to further that end.

APPENDIX A

STANDARDS APPLICABLE TO THE ROLE OF
THE MENTAL HEALTH PROFESSIONAL

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THE MENTAL HEALTH PROFESSIONAL

Standard G-1

The State Department of Mental Health Should Develop and Implement Policies and Procedures for the Support of Services to Abused and Neglected Children and Their Families

Standard G-2

The Local Public Health Agency Should Provide Mental Health Services for Abused and Neglected Children

Standard G-3

The State Department of Mental Health Should Participate on the State Child Protection Coordinating Committee, and Local Mental Health Practitioners Should Participate on the Community Child Protection Coordinating Council

Standard G-4

Mental Health Practitioners and Mental Health Facilities Should Accord Equal Priority to Child Abuse and Neglect Mental Health Services

Standard G-5

All Aspects of the Mental Health System Should Fulfill Their Ethical Responsibility to Those They Serve by Ensuring Their Rights Are Protected

Standard G-6

Mental Health Practitioners Should be Aware that Their Personal Feelings, Attitudes, Training and Work Environment Affect Interactions With Clients, Particularly in Child Abuse and Neglect Cases

Standard G-7

Mental Health Practitioners and Facilities, in Cooperation With Other Community and Professional Organizations, Should be Advocates for Changes in Social, Political, and Environmental Conditions Which Affect the Incidence and Severity of Child Abuse and Neglect

Standard G-8

Mental Health Practitioners Should Develop Programs and Provide Services to Help Parents Improve Their Parenting Skills and Knowledge

Standard G-9

Mental Health Practitioners Should Develop Programs and Provide Services for Individuals and Families Who Are in Crisis Or Are At Risk

Standard G-10

Mental Health Facilities Should Offer a Range of Child Abuse and Neglect Treatment Services to Reach the Child, the Parents and the Family As a Unit

Standard G-11

Mental Health Practitioners Should Learn and Use the Indicators of Child Abuse and Neglect and Comply with Reporting Requirements and Procedures When Child Abuse or Neglect is Suspected

Standard G-12

Mental Health Practitioners and Facilities Should Cooperate With Other Community Organizations and Systems Involved With Child Abuse and Neglect and Should Participate on Multidisciplinary Teams

Standard G-13

Mental Health Practitioners and Mental Health Facilities Should Provide and Participate in Professional Training on Child Abuse and Neglect Prevention, Identification, and Treatment

Standard G-14

The State Department of Mental Health and the Local Public Health Agency should Conduct an Annual Evaluation of Their Child Abuse and Neglect Prevention and Treatment Efforts

APPENDIX B

**SAMPLE QUALIFIED SERVICE
ORGANIZATION AGREEMENT**

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS AND CHILD ABUSE AND NEGLECT REPORTING

In view of questions which have been raised concerning the apparent conflict between federal statutes and regulations protecting the confidentiality of alcohol and drug abuse patient records and state laws regarding child abuse and neglect reporting, the National Center on Child Abuse and Neglect (NCCAN) and the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), organizational components of the Department of Health, Education, and Welfare, have developed guidelines which will assist states and organizations in promoting child abuse and neglect reporting consistent with the federal requirements for patient record confidentiality.

The Child Abuse Prevention and Treatment Act, as amended (42 U.S.C. 5101, et seq.)¹, encourages the reporting of child abuse and neglect by providing for federal grant assistance to states which enact statutes requiring such reporting. Section 333 of the Comprehensive Alcohol Abuse and Alcoholism, Prevention, Treatment, and Rehabilitation Act of 1970, as amended (42 U.S.C. 4582)², section 408 of the Drug Abuse Office and Treatment Act of 1972, as amended (21 U.S.C. 1175)³, and implementing regulations⁴, restrict disclosure of information concerning patients maintained in connection with the provision of drug and alcohol abuse diagnosis and treatment (or referral for treatment) services which are federally assisted, either directly or indirectly. It is the view of the National Center on Child Abuse and Neglect and the Alcohol, Drug Abuse, and Mental Health Administration that the purposes of the federal and state statutes pertaining to child abuse and neglect reporting and the federal confidentiality requirements can be accommodated as set forth in this guidance.

In response to increasing awareness of the nationwide prevalence of alcohol and drug abuse, and its health, social, and economic consequences, the Congress enacted legislation which provided for federal assistance (both through formula and project grants) to states for the treatment and rehabilitation of alcohol and drug abusers. Early in the history of these programs, it became apparent that the social and economic stigma attached to persons identified as alcohol or drug abusers discouraged many persons from seeking treatment. In an attempt to encourage participation in treatment programs, the Congress mandated in the alcohol and drug abuse treatment acts that the records of alcohol and drug abuse patients be kept confidential, except that the law permits limited

¹ Enacted by Public Law 93-247 and amended by Public Law 93-644.

² Enacted by Public Law 91-616 and amended by sec. 122(a) of Public Law 93-282.

³ Enacted by Public Law 92-255 and amended by sec. 303 of Public Law 93-282.

⁴ 42 CFR Part 2.

disclosures where written consent is obtained from the patient or without written consent in the case of medical emergencies, scientific research, management audits, financial audits, program evaluation, and pursuant to an authorizing court order.

The Congress responded to an increasing awareness of child abuse and neglect problems by encouraging states (through the enactment of a statute authorizing federal grant assistance), to adopt effective child abuse and neglect reporting laws. These comprehensive reporting laws are part of a broader effort directed toward strengthening the social services made available to abused or neglected children and their families.

The federal statutes pertaining to child abuse and neglect and to the confidentiality of alcohol and drug abuse patient records were enacted to serve valid purposes. There is no indication of a congressional intent that the confidentiality statutes should absolutely preclude alcohol or drug abuse service providers from reporting child abuse, or that the receipt of drug or alcohol treatment should give rise to any presumption that a patient neglects or abuses his or her children. In order to construe both the confidentiality and child abuse and neglect laws in their proper frame of reference, the NCCAN and the ADAMHA recommend that the following procedures be used where it is suspected that there has been child abuse or neglect by a patient receiving federally assisted alcohol or drug abuse diagnostic and treatment (or referral for treatment) services.

If an alcohol or drug abuse service provider subject to the confidentiality regulations⁵, believes that cases of child abuse or neglect by its patients may come to its attention, and desires to comply with a state requirement that such cases be reported, the service provider is encouraged to enter into a qualified service organization agreement⁶, with the appropriate child protective agency. While this agreement would bind the child abuse protective agency to maintain confidentiality in accordance with the federal regulations, it would enable the service provider to comply with both the federal confidentiality requirements and the state child abuse and neglect reporting requirements.

Under the qualified service organization agreement the child protective agency would agree to provide services aimed at preventing or treating child maltreatment such as day care, nutritional and child rearing training, individual and group therapy, and other such services to drug and alcohol abuse patients suspected of child abuse. In order to meet the pertinent requirements of the confidentiality regulations (42 CFR § 2.11(n)), the child protective agency would, in the written

⁵ See 42 CFR § 2.12.

⁶ See 42 CFR § 2.11(m) and (n).

agreement, (1) acknowledge that it is fully bound by the provisions of the confidentiality regulations in the handling of any alcohol or drug abuse patient information received from the service provider, (2) agree to institute appropriate procedures for safeguarding the information, and (3) agree to resist in judicial proceedings any efforts to obtain access to patient information except as expressly provided in the confidentiality regulations.

Because the child protective agency would, under the agreement, be bound by the restrictions of the confidentiality regulations with respect to the patient information obtained from the service provider, it could not use that information to conduct an investigation or prosecution of a patient without an authorizing court order⁷, and information identifying an individual as a drug or alcohol abuse patient could not be disclosed except in accordance with the regulations.

Under such an agreement, when staff personnel at an alcohol or drug abuse service provider have reason to know or suspect that a child of one of their patients is being abused or neglected (whether because of a home visit, something that happened at the program site, or on the basis of statements from the client), the staff would report this concern to the appropriate local child protective agency. The local child protective agency is a social service agency (usually funded under Title XX of the federal Social Security Act) and would accept the report as a referral for services. The child protective agency would then contact the parent or parents involved, usually making a home visit. At that time, it would offer the family, for its acceptance or refusal, such social services as would appear necessary to deal with the alleged maltreatment or to assist the parents with any other personal or family problems they may have. In approximately 80% of child protective cases the parents accept the services of the child protective agency when they are offered.

Ordinarily, if parents refuse to accept the services and the child protective agency believes that the child has been neglected or abused, the child protective agency will seek more information or petition a court to obtain a protective order. An authorizing court order would be necessary to permit the pursuit of the former alternative since in that case the patient record obtained from the provider of drug or alcohol abuse services would be used to conduct an investigation of a patient within the meaning of 21 U.S.C. 1175(c) and 42 U.S.C. 4582(c). If a protective order is sought after the refusal of a parent or parents to accept the child protective services, any disclosure of information identifying a parent as an alcohol or drug abuser would, under the confidentiality regulations, be permissible only if an authorizing order could, of course, be made concurrently with the petition for a protective order. Attached is an outline for an authorizing court order which meets

⁷ See 21 U.S.C. 1175(c), 42 U.S.C. 4582(c) and 42 CFR § 2.65.

the requirements of the confidentiality statutes and regulations.

There are many advantages to be derived from qualified service organization agreements. For example, they would increase the protection afforded to endangered children without recourse to artificial and stigmatizing presumptions, and they would expand services available to the clients in drug and alcohol treatment programs to include such additional services as homemakers, day care, nutritional and child rearing training, as well as individual and group therapy. Additionally, they would afford new opportunities for discussion between child protective, child welfare, and public social service agencies and providers of drug and alcohol abuse services, and would encourage the public service agencies to provide training on the identification, management, and referral of child abuse and neglect situations.

SAMPLE QUALIFIED SERVICE ORGANIZATION AGREEMENT

Whereas the _____ provides
name of service organization

_____ to the
type of service provided by organization to program

_____ and whereas the _____
name of service organization

needs the following information _____
specify information

in order to provide its services to the program; and whereas the disclosure of this information is governed by the Federal Regulations on the Confidentiality of Alcohol and Drug Abuse Patient Records 42CFR Part 2. Therefore the _____ and the _____

name of service organization *name of program*

enter into a qualified service organization agreement whereby the

name of service organization

1. Acknowledges that in receiving, storing, or otherwise dealing with any information from the program about the patients in the program that it is fully bound by the requirements of 42CFR Part 2;
2. Agrees that it will institute appropriate procedures for safeguarding such information, particularly patient identifying information; and
3. Agrees that it will resist in judicial proceedings any efforts to obtain access to any information pertaining to patients otherwise than expressly provided for in 42CFR Part 2.
4. THE _____ RECOGNIZES THAT ANY UNAUTHORIZED DIS-
service organization
CLOSURE OF PATIENT INFORMATION IS A FEDERAL CRIMINAL OFFENSE PUNISHABLE BY A FINE OF NOT MORE THAN \$500.00 IN THE CASE OF A FIRST OFFENSE AND NOT MORE THAN \$5,000.00 IN THE CASE OF EACH SUBSEQUENT OFFENSE.

Executed this _____ day of _____ 19 _____.

Signature of Service Organization

Signature of Program

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